CITY OF BALTIMORE

HEALTH DEPT.

BUREAU OF

VITAL STATISTICS

DEATHS

BEGINNING 1940

EP 63907

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE DEPARTMENT OF Health BUREAU OF Vital Statistics CREATED DURING THE NORMAL COURSE OF BUSINESS AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COMPLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PROVIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION NO. 345 AS APPROVED BY THE RECORDS COMMITTEE IN ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR ON JUNE 4, 1954.

FORM RM-1 (11-58) RETAIN—PERM.

Authorization No. 345

REQUEST FOR RETENTION PERIOD

Department: Health

To: Records Management Officer, Room 408, City Hall, Baltimore, 2, Md.

Bureau: Vital Statistics

Record Identification

1. TITLE:	2. Form No. if available	3. Type—(cards, paper, etc.)
Certificate of Death		Bound Book

4. Dates	5. Volume accumulated yearly	6. Size of Record	7. Number of copies made
		Misc.	One (1)

8. Authorization Requested (check only one (1) of the squares below)

A. ☐ Establish retention period for records which are accumulating daily.

B. ☐ Dispose of present accumulation, no additional accumulation anticipated.

C. ☐ Microfilm and destroy originals.

D. ☒ Microfilm and retain originals for length of time indicated below.

9. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	10. Equipment and space freed.	11. In your opinion does this record have any historical significance?
12 yrs.	Micro. Perm.	12 yrs. and Micro. Perm.		YES ☐ NO ☒

12. DESCRIPTION OF RECORD: (describe accurately and show recommended retention period.)

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.

Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval Robert E. Farber M.D. Title: Commissioner of Health 3/28/63 Date

Recommendation of Records Management Officer

13. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	14. Disposal Method A	B	C
12 yrs.	Microfilm Permanent	12 yrs. and Microfilm Permanent	☐ To be sold as scrap or waste paper	☒ To be Burned or shredded	☐ Historical, (to be transferred to Dept. of Legislative Reference.)

REMARKS:

C P Boyce Records Management Officer 3/29/63 Date

APPROVALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER ROOM 408, CITY HALL, BALTIMORE 2, MD.

1. APPROVED: CITY AUDITOR

2. APPROVED: CITY SOLICITOR

3. APPROVED: CITY COMPTROLLER

4. APPROVED: CITY TREASURER

5. APPROVED: DIRECTOR, DEPT. OF PUBLIC WORKS

6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM

7. APPROVED: DIRECTOR, DEPT. OF LEGISLATIVE REFERENCE

FILED ON FILM

IN

NUMERICAL ORDER

G49326

505745.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 48B

Registered No. G49326

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 904 S. Russell St (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Ella Jones.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....
6 (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) 11-6-78

8. AGE: Years 68 | Months 4 | Days - | If less than one day .....hr. .....min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER 12. Name ? ?
13. Birthplace ?.

MOTHER 14. Maiden Name ? ?
15. Birthplace ?.

16 (a) Informant Rhonda.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 | 9 | 47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A.A. Co. Md

18 (a) Funeral director Isaiah L Brown Son
(b) Address 1286 Montgomery St

MAR 7 - 1947

19 (a)..... (b)..... (Date rec'd by registrar) Washington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March - 6 1947, at 345 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec - 3 1946, to March - 6 1947, and that I last saw h. m alive on March - 6 1947.

Immediate cause of death adeno carcinoma metastases — Duration .....

Due to adeno carcinoma ulcus — Duration .....

Due to ..... — Duration .....

Other Conditions Dehydration Urinary tract infection Acute abscess (Include pregnancy within 3 months of death) — Duration .....

Date of operation.....

Major findings of operation:.....

of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature H. E. Mohrmann Jr M.D.
Address The Johns Hopkins Hospital Date signed 3-6-47 M. D.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C49327.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 307

Registered No. C49327

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 213 Otterbein st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grant Bailey

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-09-1788

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1849

8. AGE: Years 98 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name James Bailey
13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Mary Jones
15. Birthplace Baltimore Md

16 (a) Informant Florence Bailey
(b) Address 213 Otterbein st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co. Md

18 (a) Funeral director Daniel J Brandon
(b) Address 1018 Montgomery st

19 (a) MAR 7 1947 (Date rec'd by registrar) Hunting for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1947, at 6:50 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hemorrhage

Due to Gastric Ulcer

Other Conditions Syphilitic aortitis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D.
Medical Examiner.
Date signed 3-4-47

VS 151

1170

G49328

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G49328 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 N Gay St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John P Volk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29 1852

8. AGE: Years 94 | Months 8 | Days 7 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Conrad Volk
13. Birthplace Germany

MOTHER 14. Maiden Name Dorothea Adams
15. Birthplace Germany

16 (a) Informant Mrs Margaret Volk
(b) Address 1000 N Gay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-10-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director Wm J Oberthur
(b) Address 3601 Fairfield

MAR 7 - 1947 (Date rec'd by registrar) (c) Huntingtown Williamsport Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1947 at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/28 1947 to 3/6 1947, and that I last saw him alive on 2/24 1947

Immediate cause of death Coronary Thrombosis — Duration Sudden

Due to Arterio-sclerotic Cardio-vascular Disease — Duration 10 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis Frieden M. D.

Address 1206 E Preston St Date signed 3/7/47

G49329 Dr Kleiman 3803 Edmondson Ave Thursday G49329

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No.

MARGIN RESERVED FOR BINDING. The PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 412 Westgate Rd
(c) Hospital or institution: 4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 412 Westgate Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine F. Norris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife John H. Norris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 7th 1877

8. AGE: Years	Months	Days	If less than one day
69	5	28	hr. min.

9. Birthplace St. Mary's Co. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Martin E. Combs
13. Birthplace St. Mary's Co. Md.

MOTHER
14. Maiden Name Sarah Dorsey
15. Birthplace St. Mary's Co. Md.

16 (a) Informant John H. Norris
(b) Address 3708 Gelston Drive

17 (a) Burial (b) Date thereof 3/8/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul st

19 (a) MAR 7 - 1947 (b) Huntington Williams, MD
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 5th 1947, at 6.40 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 27 1947 to March 5 1947 and that I last saw h CK alive on March 5 1947.

Immediate cause of death CORONARY THROMBOSIS — Duration 6 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norman R Kleiman
Address 3803 Edmondson Ave Date signed 3/6/47 D

C49330

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. C49330

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 620 St. Ann's Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 620 St. Ann's Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John Buckley

3 (b) If veteran, name war

3 (c) Social Security Account N219-09-3438

4. Sex Male | 5. Color or race White | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~. Married

6 (b) Name of ~~husband or~~ wife Kate Buckley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1866

8. AGE: Years	Months	Days	If less than one day
80	11		hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Cement Finisher

11. Industry or business Roland Park Co.

FATHER
12. Name Buckley
13. Birthplace Ireland

MOTHER
14. Maiden Name
15. Birthplace Ireland

16 (a) Informant Mrs Kate Buckley
(b) Address 620 St. Anns Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/47 (month) (day) (year)
(c) Cemetery or crematory St. Peters
Location Balto. Md.

18 (a) Funeral director Williams Cook Inc
(b) Address 1217 St. Paul St.

19 (a) MAR 7 1947 (Date rec'd by registrar) (b) Huntington for Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 5th 1947, at 6:30 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1946 to March 5 1947 and that I last saw him alive on March 1 1947.

Immediate cause of death	Duration
Due to Endocarditis	10 yrs.
Due to Chronic Congestive Heart Failure	5 years
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edwin K. Ballard M.D.
Address 1622 Mt. Royal Ave Date signed 3-6/1947

G49331

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G49331 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 132 S. Carey St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 132 S. CAREY ST
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARY F. COOK

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex FEMALE

5. Color or race WHITE

6 (a) Single, married, widowed, or divorced. WIDOW

6 (b) Name of husband or wife Deceased

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 9 | 20 | 1879

8. AGE: Years 67 | Months 6 | Days 16 | If less than one day — hr. — min.

9. Birthplace BALTIMORE – Md
(Town, county, and state)

10. Usual Occupation HOUSEKEEPER

11. Industry or business

FATHER
12. Name HARRY MORAN KRONAU
13. Birthplace BALTO – Md.

MOTHER
14. Maiden Name MARY ESTELLE ESLE
15. Birthplace BALTO. Md

16 (a) Informant JOHN L. KRONAU
(b) Address 501 WILTON ROAD

17 (a) BURIAL (b) Date thereof 3 | 8 | 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory WESTERN CEMETERY
Location

18 (a) Funeral director THOS. J. KENNY, INC
(b) Address HOLLINS and GILMOR STS.

19 (a) (Date rec'd by registrar) (b) Registrar

vs 1947 MAR 7 – Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1947, at 8 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 5 1946, to March 6 1947 and that I last saw h[illegible] alive on March 6 1947.

Immediate cause of death	Duration
Cardiac Failure	
Due to Carcinoma of Cervix Uteri	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert Scarmatta, M.D.
Address 1729 W Lombard Date signed 3/7/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G49332

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 604 Stamford Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Minnie A. Arnold

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Franklin P.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-17-1862

8. AGE: Years 84 | Months 11 | Days 17 | If less than one day 20 hr. min.

9. Birthplace W. Va. (Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name John West
13. Birthplace W. Virginia

MOTHER
14. Maiden Name Unknown
15. Birthplace West Va.

16 (a) Informant Mrs Alice Arnold
(b) Address 604 Stamford Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 (month) 9 (day) 47 (year)
(c) Cemetery or crematory Loudon Park Cem.
Location 3801 Hedgefield Ave.

18 (a) Funeral director John J. Gowan & Son
(b) Address 901-03 Hollins St.

19 (a) 1947 (Date received by Registrar) (b) Burying for Williams Mfg. Co. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1947 2:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-3 1947 to 3-6 1947 and that I last saw h[illegible] alive on 3-6 1947

Immediate cause of death	Duration
Cardiac failure	
Bile peritonitis - perforated	
Duodenal ulcer	
Due to	
Due to	
Other Conditions Gen'l arteriosclerosis	
Hodgkin's Coronary (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]
Address Hospital Date signed 3/6/47 M. D.

VS 150

G49333

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G49333
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2421 Hudson Place D.O.A.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2421 Hudson Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Henderson

3 (b) If veteran, name war

3 (c) Social Security Account No. 223-05-3741

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8, 1905

8. AGE: Years	Months	Days	If less than one day
41	7	24	hr. min.

9. Birthplace Henderson, N. C.
(Town, county, and state)

10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Joseph Henderson
13. Birthplace North Carolina

MOTHER
14. Maiden Name Mary Yancy
15. Birthplace North Carolina

16 (a) Informant Esther Thomas
(b) Address 1012 Whatcoat St.

17 (a) Burial (b) Date thereof 3/7/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Edgar Hill, Md.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) 3-7-19[illegible] (b) Huntington Williams M.D.
(Signature of registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/2 1947, at 9:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to b.g. death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bronchopneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Sulwinski M.D.
Medical Examiner.
Date signed 3/3/47

VS 131

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49334

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 55E

Registered No. G49334

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) ~~City~~ or town Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1708 Earhart Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Addie Addrell Wade Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed, or divorced~~
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 17th 1940

8. AGE: Years	Months	Days	If less than one day
6	5	19	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Addie Wade
13. Birthplace Va.

MOTHER
14. Maiden Name Alva Duffey
15. Birthplace Va.

16 (a) Informant Addie Wade
(b) Address 1708 Earhart Rd Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof MAR. 8 1947 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location BALTO. CO. MD.

18 (a) Funeral director Williams Cook Inc
(b) Address 127 St. Paul St

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 7 - 1947

Investigator Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1947, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 22 1947 to March 6 1947, and that I last saw him alive on March 6 1947.

Immediate cause of death	Duration
Lymphosarcoma	
Due to	
Due to	
Other Conditions Orchidectomy, rt.	

(Include pregnancy within 3 months of death)

Date of operation Feb 28, 1947

Major findings of operation: Lymphosarcoma

of autopsy Lymphosarcoma

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Morris J. Michael M. D.

Address Sinai Hosp. Date signed 3-6-47

N

B.R.# 7-11069

G49335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 64

Registered No. G49335

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2914 Clearview Avenue
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) no
(e) Length of stay in Baltimore (yrs., mos., or days) no

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2914 Clearview Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lois Marie Steiner

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: no
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 15, 1947

8. AGE: Years | Months | Days: 19 | If less than one day: hr. min.

9. Birthplace: Baltimore
(Town, county, and state)

10. Usual Occupation: no

11. Industry or business: no

FATHER
12. Name: Nelson F. Steiner
13. Birthplace: Baltimore

MOTHER
14. Maiden Name: Emma Jackson
15. Birthplace: Baltimore

16 (a) Informant: Nelson F. Steiner
(b) Address 2914 Clearview Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 7- (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director: Wm. Cook, Inc.
(b) Address 1217 St. Paul St.

19 (a) (Date rec'd by registrar) (b) [illegible] Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1947, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 19 1947, to March 6 1947, and that I last saw h.r. alive on March 4 1947

Immediate cause of death: Enlarged Thymus — Duration: 2/c

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Karl W. Elsberg M. D.

Address 3311 St Paul St Date signed 3/7/47

Elsberg X

G49336

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G49336 Registered No. 186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Severna Park
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cornelia Elizabeth Frank

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Robert W. Frank
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 17, 1868

8. AGE: Years: 78 | Months: 7 | Days: 18 | If less than one day: hr. min.

9. Birthplace: Towson, Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Joseph S. Bowan
13. Birthplace: Baltimore Co., Md.

MOTHER
14. Maiden Name: Lydia Parks
15. Birthplace: Balto. Co., Md.

16 (a) Informant: Mr. Robert B. Frank
(b) Address: Severna Park, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/47 (month) (day) (year)
(c) Cemetery or crematory: St. Johns Cem.
Location: Waverly, Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) MAR 7 - 1947 (Date rec'd by registrar) (b) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1947 at 4:40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Valvular Heart Disease + Mitral + Aortic Insufficiency

Due to

Other Conditions Fracture, Left hip (Intertrochanteric) - Emphysema of Urinary Bladder (Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury 2/11/47 at 12:30 P.M.
(b) Where did injury occur? Entrance Lounge St
(c) Did injury occur at home, on farm, industrial place, in public place? Regent Lounge While at work? No
(d) Means of injury Fell down stairs

23. Signature Earl L Koons M.D.
Medical Examiner.
Date signed 3-6-47

G49337

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G49337

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-7
(e) Length of stay in Baltimore (yrs., mos., or days) All

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2921 Brighton Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALBERTA ESTELLE BILLMYER

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Eugene William Billmyer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Oct. 15, 1878

8. AGE: Years	Months	Days	If less than one day
68	4	21	hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Phillip Horn
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Rose Lambert
15. Birthplace: Balto., Md.

16 (a) Informant: Mr. D. E. Billmyer, son
(b) Address: 2921 Brighton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/10/47 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Baltimore, Md.

19 (a) (Date rec'd by registrar) 1947 (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/6/47 19 , at 1:55p M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Hypertensive Cardiovascular Disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Weis, Medical Examiner M.D.
Date signed 3/6/47

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49338

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G49338

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3108 Baker St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3108 Baker St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EUGENE SMITH

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	215-09-3871

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Mary C. Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 17, 1875

8. AGE: Years	Months	Days	If less than one day
71	2	18	hr. min.

9. Birthplace Somerset Co., Md. (Town, county, and state)
10. Usual Occupation Conductor
11. Industry or business Baltimore Transit Co.

FATHER
12. Name John C. Smith
13. Birthplace Md.

MOTHER
14. Maiden Name Mary C. Somers
15. Birthplace Md.

16 (a) Informant Mrs. Mary C. Smith
(b) Address 3108 Baker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5, 1947, at 12 A M

21. I certify that death occured on the date above stated; that I attended deceased from April 19 42 Mar 5 1947 and that I last saw h[illegible] alive on Mar. 4 1947

	Duration
Immediate cause of death Cerebral Hemorrhage	9 hrs
Due to Essential hypertension	15 yrs
Due to	
Other Conditions Arrested pulmonary tuberculosis.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Krenger
Address 1402 E. Fairmount Ave. Date signed 3-6-47

MAR 7 - 1947 Huntington Williams, M.D.

VS 150

X

G49339

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G49339

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3107 Rosekemp Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3107 Rosekemp Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES FREDERICK HOFFMAN

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Lillian Hoffman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 3, 1879

8. AGE: Years 67 | Months 6 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Shipping Dept.

11. Industry or business McCormick & Co.

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Miss Ella Stehli
(b) Address 3107 Rosekemp Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MAR 7 - 1947

Tuntington Williamsville, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5, 1947, at 7:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/27 1947 to 3/5 1947 and that I last saw h[illegible] alive on 3/4 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	6 days
Due to Hypertensive Cardiovascular Disease	2 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John J. Schaefer M.D.

Address 2128 St. Paul St. Date signed 3/5/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49340

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 186a

G49340 ✓ Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2646 Guilford Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Lucy Stone Waller

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: William Waller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 24, 1862

8. AGE: Years 84 | Months 5 | Days 12 | If less than one day: hr. min.

9. Birthplace Maryland, (Princess Anne) (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James M. Stone
13. Birthplace Md.

MOTHER
14. Maiden Name Lucina G. Jones
15. Birthplace Md.

16 (a) Informant Mr. James M. S. Waller
(b) Address 2646 Guilford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/47 (month) (day) (year)
(c) Cemetery or crematory Govans Presby. Cem.
Location Govans, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 7 - (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/6 1947 at 8 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/27 1947 to 3/6 1947.
and that I last saw her alive on 3/6 1947.

Immediate cause of death: Fat Embolism — Duration 2 days
Due to: Fractured Right Hip — 7 days
Due to:
Other Conditions: Hypertension — 10 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 12/3
(a) Accident, suicide, or homicide Accidental
(b) Date of occurrence 2-28-47 at ? M
(c) Where did injury occur? 2646 Guilford Ave (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? no
(e) Means of injury: Slipped on polished floor
23. Signature: [illegible]
Address Franklin Sq. Hosp. Date signed 3/6/47 M D

To be approved by Med. Examiner — Thomas J. Mullen, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92D

Registered No. G49341

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 503 S. ANN ST.
(c) Hospital or institution: 7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 503 S. ANN ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JADWIGA JAROSZEWSKI

3 (b) If veteran, name war

3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife NIKODEM

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1902

8. AGE: Years	Months	Days	If less than one day
45			hr. min.

9. Birthplace POLAND
(Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name LEON GRZEGORZAK
13. Birthplace POLAND

MOTHER
14. Maiden Name LEONARDA PODIACKI
15. Birthplace POLAND

16 (a) Informant NIKODEM JAROSEWSKI
(b) Address 503 S. ANN ST.

17 (a) BURIAL (b) Date thereof MCH. 10-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory HOLY ROSARY
Location BALTIMORE

18 (a) Funeral director Fred W. Ozarowski
(b) Address 1900 Eastern Ave. Huntington Williams, Reg.

19 (a) MAR. [illegible] (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 5 1947, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Novemb 2 1945 to March 5 1947 and that I last saw him alive on March 4 1947

Immediate cause of death Valvular heart disease

Due to acute dilatation of the heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

Duration
16 months
5 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel Silverstein M.D.
M. D.
Address 22 E. Broadway Date signed March 7-47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49342

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122 B

Registered No. G49342

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 315 Wise Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Ada Hillegas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	M.

6 (b) Name of husband or wife Bernard Hillegas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 8, 1903

8. AGE: Years	Months	Days	If less than one day
43	2	28	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Hale
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Ada Kimber
15. Birthplace Pennsylvania

16 (a) Informant Husband
(b) Address

17 (a) Removal (b) Date thereof 3/7/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Huntingtown P.O. Md

18 (a) Funeral director John E. Miller Jr.
(b) Address Lutherville Md

19 MAR 7 - 1947 (b) Huntingtown Williamsport
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-6 1947 at 5:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1 1947 to Mar 6 1947 and that I last saw h. alive on Mar 6 1947.

Immediate cause of death	Duration
Cardiac resp failure - Perforated duodenal collapse	
Due to Generalized Peritonitis	24 hrs.
Due to	
Other Conditions Intestinal obstruction	24 hrs.

(Include pregnancy within 3 months of death)
Date of operation 3-3-47
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E. May
Address Mercy Hospital Date signed 3-8-47 M. D.

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49343

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G49343

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1824 Presstman St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1631 N. Carey St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Franklin Squirrel

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	Col	M

6 (b) Name of husband or wife Eugene

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ~~July~~ July 22, 1920

8. AGE: Years	Months	Days	If less than one day
26	7	13	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Ernest Franklin
13. Birthplace Md.

MOTHER
14. Maiden Name Rebecca Rhodes
15. Birthplace Md.

16 (a) Informant Eugene Squirrel
(b) Address 1631 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/7/47 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Md.

18 (a) Funeral director Geo. G. Kelson
(b) Address 1303 Presstman St.

19 (a) Date received by Local Registrar MAR 7 - 1947 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/25 1947 to 3/3/ 1947 and that I last saw h alive on March 3 1947

Immediate cause of death	Duration
Pulmonary Tuberculosis	2 yrs 8 months
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. I. Peters M. D.
Address 87 Hamilton Ter. Date signed 3-7-47

G49312 ROBINA

BALTIMORE CITY HEALTH DEPARTMENT.

CERTIFICATE OF DEATH 13B

Registered No. G49312

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd St. & Guilford Ave.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 44

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 10 (If outside city or town limits, write RURAL and give town)
(d) Street No. Tudor Arms Apartments (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ROBINA MARY SHERWOOD

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1905

8. AGE: Years	Months	Days	If less than one day
41	5	18	20 hr. — min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation Secretary
11. Industry or business —

FATHER
12. Name John Henry Sherwood
13. Birthplace Virginia

MOTHER
14. Maiden Name Jeannette Hopper
15. Birthplace Baltimore, Md.

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore County, Md.

18 (a) Funeral director H. H. Mears & Son
(b) Address 805 N. Calvert St.

19 MAR 7 - 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5, 1947 at 4:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 5, 1947 to March 5, 1947 and that I last saw h.e. alive on March 5, 1947

Immediate cause of death	Duration
Uremia	3 days
Due to Hypertensive cardiovascular disease	?
Due to	
Other Conditions Pulmonary tuberculosis	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman R. Freeman M.D.
Address Union Memorial Hosp. Date signed March 5, 1947

VS 150

93D

G49345 BGH 6/12/70

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G49345
Registered No.

CERTIFICATE OF DEATH 74a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Olmer & Conkling
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 54 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2702 Yorkaway - 22 (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Selvey [redacted] C. Hayes Jr.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 10/25/44

8. AGE: Years	Months	Days	If less than one day
2	4	10	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER 12. Name Selvey C. Hayes
13. Birthplace Ohio
MOTHER 14. Maiden Name Josephine —
15. Birthplace W. Va.

16 (a) Informant Selvey C. Hayes
(b) Address 2702 Yorkway, Dundalk 22 Md.
17 (a) Removal (Burial, cremation, or removal) (b) Date thereof March 8, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Hope
Location Mt. Hope, New York
18 (a) Funeral director Roland L. Fleker
(b) Address 2112 Dundalk Ave.
19 (a) (b)
MAR 7 1947 Huntington, West Virginia
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/7/1947, at 7 AM
21. I certify that death occurred on the date above stated; that I attended deceased from 1/11/47 1947, to 3/7/1947 and that I last saw h.i.m alive on 3/7/1947.

Immediate cause of death	Duration
CARDIO-Respiratory Failure	
Due to Lymphatic Leukemia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Richard A. Young M. D.
Address St. Josephs Hosp Date signed 3/7

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C49346

BALTIMORE CITY HEALTH DEPARTMENT.

CWK-108744 **CERTIFICATE OF DEATH** 13 B

Registered No. C49346

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 McElderry Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME [illegible] (Miller Cummings)

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-20-6690

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
50 ?			hr. min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location A. A. Co. Md.

18 (a) Funeral director Robert E. Williams
(b) Address 1575 McElderry St

19 (a) Filed MAR 7 1947 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH February 28 1947, at 2:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 27 1947 to Feb. 28 1947, and that I last saw him alive on Feb. 28 1947.

Immediate cause of death	Duration
(a) C-V accident.	
Due to (b) Generalized Atherosclerosis	
Due to (c)	
Other Conditions Pulmonary Tb, far advanced	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert A. Fauber M. D.
Address Balto City Hosps Date signed 3-25-47

83a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49347

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G49347 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 Hilton Road,
(c) Hospital or institution: Ashburton Nursing Home,
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2716 Inglewood Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Fink

3 (b) If veteran, name war: --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife: Peter Fink
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6, 1870

8. AGE: Years	Months	Days	If less than one day
76	11	29	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Gottleib Miller
13. Birthplace Germany

MOTHER
14. Maiden Name Louise
15. Birthplace Germany

16 (a) Informant Arthur Fink
(b) Address 2716 Inglewood Ave. 14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 8, 1947 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.,

19 (a) MAR 7 1947 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5, 1947, at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1947 to 3-3 1947, and that I last saw her alive on 3-3 1947

Immediate cause of death	Duration
Coronary thrombosis	2 or 3 min
Due to Arteriosclerosis Diabetes Mellitus	years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Dec 9, 1946

Major findings of operation: Malignancy Diabetic

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William L. Reams M.D.
Address 302 Shelar Rd Date signed 3-7-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164c

G49348 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 minutes
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 833 Jeffery St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Kay

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 251-01-5148

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mary K Kay.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Sept 4th 1911

8. AGE: Years	Months	Days	If less than one day
35	6	1	hr. min.

9. Birthplace: S. Carolina (Town, county, and state)
10. Usual Occupation: Operator
11. Industry or business: Balto. Transit

FATHER
12. Name: Benjamin T. Kay
13. Birthplace: South Carolina

MOTHER
14. Maiden Name: Velma Hiott
15. Birthplace: South Carolina

16 (a) Informant: Mary K. Kay
(b) Address: 833 Jeffery St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3-7-47 (month) (day) (year)
(c) Cemetery or crematory: Greenville
Location: Greenville South Carolina

18 (a) Funeral director: Wm Cook Sons
(b) Address: 1217 E. Fayette St

19 (a) 1947 (Date received by registrar)
MAR 7
Arlington Williams, Registrar

US 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/5 1947 at 8 20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Gunshot wound of head

Due to

Other Conditions: Pregnancy

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/5/47 at about 2 30 P.M.
(b) Where did injury occur? 833 Jeffery St
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury: Shot self in right temple with 32 Cal. pistol

23. Signature: [illegible] M.D. Medical Examiner.
Date signed 3/6/47

X

G49349

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 178a

Registered No. G49349

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 422 S. Bond Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter Kozloski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: W.

6 (b) Name of husband or wife: Pauline

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: about 68 | Months | Days | If less than one day: hr. min.

9. Birthplace: Poland (Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business

FATHER
12. Name —
13. Birthplace Poland

MOTHER
14. Maiden Name —
15. Birthplace Poland

16 (a) Informant: Josephine Mina
(b) Address 3111 Westfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 10-47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto. Co.

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern ave

19 (a) Date received by Local Reg. MAR 7 1947 (b) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6, 1947, at 9.05 A.M.

21. I certify that I took charge of the remains described above, held an insp. & inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation

Due to illuminating gas

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-6-47 at approx. 8.30 A.M. 3/11
(b) Where did injury occur? 422 S. Bond Street.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No
(d) Means of injury Gas range 1 burner opened, unlit

23. Signature Howard J. Malecki M.D.
Medical Examiner.

Date signed 3-6-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49350

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

G49350 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1722 E. Eager St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1722 E. Eager St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daisy Gladdney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 11. 1898

8. AGE: Years 48 | Months 5 | Days 21 | If less than one day hr. min.

9. Birthplace Blakeston S. C.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Coquille Gladdney
13. Birthplace South Carolina

MOTHER
14. Maiden Name Eliza Bell
15. Birthplace South Carolina

16 (a) Informant Nancy L. Foster
(b) Address 1722 E. Eager St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch 9, 1947 (month) (day) (year)
(c) Cemetery or crematory Blakeston
Location Blakeston S. C.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1700 Bridge Ave

19 (a) 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1947 at 7:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1946 to March 6 1947 and that I last saw h[illegible] alive on March 3 1947

Immediate cause of death Carcinoma metastasizing to lungs pelvic organs, etc — Duration: Sept 47

Due to Adenocarcinoma of vulva. — Duration: Sept 1946

Due to Carcinoma Cervix — Duration: 1

Other Conditions Endometritis Chr. Atrophic
(Include pregnancy within 3 months of death)

Date of operation 9/27/46

Major findings of operation: Carcinoma cervix extension to pelvic organs

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature F. E. Thompson

Address 142 E. Preston St Date signed 3/9/47

Huntington Mfg. Registrar

US 150

3-6-47 G49351 5A

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G49351

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2533 N. Howard Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2533 N. Howard Street (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE ISAAC DODSON

3 (b) If veteran, name war

3 (c) Social Security Account No. 413-12-4141

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Ottie O.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1886

8. AGE: Years	Months	Days	If less than one day
60 65	5	14	hr. min.

9. Birthplace Nashville, Tennessee (Town, county, and state)
10. Usual Occupation Stock clerk
11. Industry or business

FATHER
12. Name Samuel G. Dodson
13. Birthplace Nashville, Tennessee

MOTHER
14. Maiden Name Sophie Shelby
15. Birthplace Tennessee

16 (a) Informant Mrs. Ottie O. Johnson
(b) Address 2533 N. Howard Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 7, 1947 (month) (day) (year)
(c) Cemetery or crematory Family lot
Location Nashville, Tennessee

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b)

MAR 7 - 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1947, at 5:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 20 - 1947, to Mar. 6 1947, and that I last saw h.. alive on Mar 6 1947.

Immediate cause of death	Duration
Pneumonia Stomach	
Due to	2 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 2329 - Lucretia St Date signed Mar 7 1947

X

3-6-47
#640352

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

640352

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 545 McMechen Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 545 McMechen Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH S. JONES

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife John E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, 1897

8. AGE: Years	Months	Days	If less than one day
49	8		hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Emanuel Saunders
13. Birthplace North Carolina

MOTHER
14. Maiden Name Lucy???????
15. Birthplace North Carolina

16 (a) Informant David Jones
(b) Address 545 McMechen Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 7, 1947 (month) (day) (year)
(c) Cemetery or crematory Family lot
Location Raleigh, N.C.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) (Date received by Registrar) (b) 1947 Registrar

V S 190

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1947, at 5:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 4 1947 to Mar 6 1947 and that I last saw h[illegible] alive on Mar 6 1947

Immediate cause of death	Duration
Myocardial Degeneration	2 days
Due to	
Due to	
Other Conditions Common Diarrhea	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Franklin Phillips M.D.
Address 1543 Penna. Ave Date signed 3/7/47

MARGIN RESERVED FOR BINDING

"PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C49353 — C49353 — 83a — Registered No. C49353

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2145 Vine Street
(c) Hospital or institution: ----------
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2145 Vine Street (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME: MARY SAHLIN : MARY SAHLIN

3 (b) If veteran, name war: ********
3 (c) Social Security Account No. ********

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	Married

6 (b) Name of husband or wife Nils W.Sahlin Sr.
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Feb. 8/1879

8. AGE: Years	Months	Days	If less than one day
68	***	25	********** hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Housewife At.
11. Industry or business Home.

FATHER
12. Name John Schneppe
13. Birthplace Germany

MOTHER
14. Maiden Name unknown
15. Birthplace Germany

16 (a) Informant Mr. Nils W. Sahlin Sr.
(b) Address 2145 Vine Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 8/47 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore Md.

18 (a) Funeral director A. D. Wishart & Son
(b) Address 1300 Eutaw Place..17

19 (a) (Date received by registrar) (b) Registrar
MAR 7 - 1947 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 5th. 1947, at 1055A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/20 1947 to 3/5 1947 and that I last saw her alive on 3/5 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	5 day
Due to Arterial Sclerosis	
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas A Cashin
Address 2145 W Belvedere Date signed 3/6/47 M.D.

X

G49354

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

✓ G49354 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1114 Watson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Robert Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1923

8. AGE: Years	Months	Days	If less than one day
24			hr. min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School MAR 7 1947

18 (a) Funeral director Commissioner of Health

(b) Address

MAR 7 1947 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 15 1947, at 1:10 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Stab wound of heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-15-47 at 12:45 A M.
(b) Where did injury occur? 1114 Watson St
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Sharp Instrument

23. Signature Howard J. Weaver M.D.
Medical Examiner.
Date signed 2-15-47

VS 151

X

G49355

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

111B

G49355
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 914 N. Stricker st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) Dod
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 914 N. Stricker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucius Grant

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years	Months	Days	If less than one day
53			hr. min.

9. Birthplace Unknown
(Town, county, and state)

10. Usual Occupation Unknown
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School MAR 7 1947

18 (a) Funeral director Commissioner of Health
(b) Address

MAR 7 1947 (Date rec'd by registrar)

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MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 11 1947, at 7 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Edema.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D.
Medical Examiner.
Date signed 2/12/47

G49356 BC B72026 G49356

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

158 ✓ Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 320 N Carey St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 320 N Carey St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Jennings

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2nd 1947, at 11:50 P.M.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/27/47

8. AGE: Years | Months | Days 3 | If less than one day ____hr. ____min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER 12. Name ?
13. Birthplace

MOTHER 14. Maiden Name ?
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School MAR 7 1947

18 (a) Funeral director Commissioner of Health
(b) Address

MAR 7 1947 Huntington Williams M.D.
(Date rec'd by registrar)

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Res death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Suffocation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Huntington Williams M.D. Medical Examiner.
Date signed March 3rd 47

VS 151

2

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G49357 ✓ G49357 52B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Pulaski Sts
(c) Hospital or institution Bon Secours Hospital 13th
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 days
(e) Length of stay in Baltimore (yrs., mos., or days) 80 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 518 W. 33rd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** WALTER W. APPLEBY.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Ida M. Appleby

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 9 1866

8. AGE: Years	Months	Days	If less than one day
80	11	27	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Retired, Conductor.

11. Industry or business Penn. R. R.

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Everett R. Appleby.
(b) Address 518 W. 33rd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 8 (1947) (month) (day) (year)

(c) Cemetery or crematory St. Mary's
Location Hampden

18 (a) Funeral director Chenault & Dorsey
(b) Address 345-47 Cheatham Ave

19 (a) [illegible] 4 - 1947 (Date rec'd by registrar)

Signature [illegible] Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH March 6, 1947, at 3:45 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-5-1947, to 3-6-1947 and that I last saw him alive on 3-6-1947

	Duration
Immediate cause of death Cardiac respiratory failure	
Due to Hypertension - arterio-sclerotic C.V. disease	
Due to	
Other Conditions Infiltrating Ca carcinoma of bladder	

(Include pregnancy within 3 months of death)

Date of operation 3-5-47

Major findings of operations: Infiltrating Carcinoma of bladder

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. L. Markley, M. D.
Address Bon Secours Hosp. Date signed 3-6-47

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The PLEASE WRITE PLAINLY, WITH UNFADING INK. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49358

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G49358
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution: Elmhurst Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Hebbville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Pine Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James L. Talbert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elizabeth P. Talbert

6 (c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): April 21, 1875

8. AGE: Years: 71 | Months: 10 | Days: 15 | If less than one day: hr. min.

9. Birthplace: Anne Arundel Co., Md.
(Town, county, and state)

10. Usual Occupation: Farmer

11. Industry or business

FATHER
12. Name: Samuel Talbert
13. Birthplace: Anne Arundel Co., Md.

MOTHER
14. Maiden Name: Josephine Rigdon
15. Birthplace: Maryland

16 (a) Informant: Mrs. Elizabeth P. Talbert
(b) Address: Pine Ave., Hebbville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: March 8, 1947 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olive Cemetery
Location: Randallstown, Md.

18 (a) Funeral director: Miller Funeral
(b) Address: 4510 Liberty Heights Ave.

19 (a) (Date rec'd by registrar) MAR 7 - 1947 (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 6 1947, at 4.45AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 3 1947 to March 5 1947, and that I last saw him alive on 19

Immediate cause of death: Coronary Thrombosis — Duration:
Due to: Advanced Arteriosclerosis
Due to: Previous cerebral Hemorrhage
Other Conditions: Partial Paralysis + Chr. Bronchitis
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Louis Jacobs M. D.
Address: 1700 Eutaw Place Date signed: 3-6-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49359

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61 ✓

Registered No. G49359

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4001 Chatham Rd.
(c) Hospital or institution:
15 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life...

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4001 Chatham Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE M.PFEFFER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Rosalie Everitt Pfeffer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1874

8. AGE: Years	Months	Days	If less than one day
72	4	3	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Book seller

FATHER
12. Name August P. Pfeffer
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. C. Edgar Pfeffer
(b) Address 119 Forest Drive

17 (a) Burial (b) Date thereof 3/10/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) MAR 7 - 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6, 1947, at 8:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 25 1946 to 19..., and that I last saw him alive on Dec 23, 1946.

Immediate cause of death	Duration
angina pectoris.	
Due to Previous coronary thrombosis.	
Due to Arteriosclerosis Diabetes Mellitus	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Gilbert T. King M. D.
Address 1210 Eutaw Pl. Date signed March 7 1947

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

649360

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No. G49360

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident
(d) Length of stay in hospital or inst. (yrs., mos., or days) 49 days
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 130 N. Castle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James McQueen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/11/94

8. AGE: Years	Months	Days	If less than one day
52	6	23	hr. min.

9. Birthplace Cheraw, S. C.
(Town, county, and state)

10. Usual Occupation Saloon

11. Industry or business

FATHER 12. Name Stephen McQueen
13. Birthplace Cheraw S.C.

MOTHER 14. Maiden Name Virginia Reed
15. Birthplace Cheraw S.C.

16 (a) Informant Hattie Harrington
(b) Address 130 N. Castle St

17 (a) Burial (b) Date thereof March 9 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Smithsonville Cem.
Location Cheraw S.C.

18 (a) Funeral director Chas O. Wilson
(b) Address 400 Bentley ave

19 MAR 7 - 1947 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/8 1947, at 12 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/13 1947, to 3/3 1947, and that I last saw h[illegible] alive on 3/7 1947.

Immediate cause of death	Duration
Atrophic Cirrhosis of Liver	3 wks
Due to	
Due to	
Other Conditions Gastric Hypertrophy CPC of Lungs. Malnutrition	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Atrophic Cirrhosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James D. Carr
Address 515 Harden St Date signed 3.5.47 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49361

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G49361

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2609 Barclay Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2609 Barclay Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET M. CONSIDINE

3 (b) If veteran, name war ——
3 (c) Social Security Account No. ——

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Dought James P.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1852

8. AGE: Years 95 | Months — | Days — | If less than one day hr. min.

9. Birthplace Foxford, Ireland (Town, county, and state)

10. Usual Occupation
11. Industry or business Housewife

FATHER
12. Name J. Doughart
13. Birthplace Ireland

MOTHER
14. Maiden Name
15. Birthplace Unknown

16 (a) Informant Mrs Sue Lorden
(b) Address 608 E Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/47 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Govans

18 (a) Funeral director WIEDEFELD AND SON
(b) Address 1947 GREENMOUNT AVE & 22ND

19 (a) MAR 8 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5th 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to Mar 5 1947 and that I last saw deceased alive on March 5 1947

Immediate cause of death: a. Bronchial Pneumonia — Duration 3 Days
Due to: b. Exhaustion
Due to: c. Age
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address Western Md. Hosp. Date signed 3-6-47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

649362

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 649362

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount Ave
(c) Hospital or institution:
Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 52 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Broadway & Fairmount Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary Evelyn Pearce

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1860

8. AGE: Years	Months	Days	If less than one day
86	6	8	hr. 23 min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business —

FATHER
12. Name William PAYNE
13. Birthplace Calvert County Md

MOTHER
14. Maiden Name Annie Sellers
15. Birthplace Calvert County Md.

16 (a) Informant Deceased
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 9, 1947 (month) (day) (year)
(c) Cemetery or crematory St. Pauls
Location Passion Frederick, Md

18 (a) Funeral director A. G. Hankins & Son
(b) Address Walkersville Md

19 MAR 8 - 1947 (Date rec'd by registrar) Thomas Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1947 at 4:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 11 1947 to Mar 7 1947 and that I last saw her alive on Mar 7 1947

Immediate cause of death Arteriosclerotic Heart Disease & Hypertension — Duration 6+ yrs

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature G. Allen Moulton M. D.
Address Church Home Hospt Date signed 3/7/47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49363

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G49363 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County 15
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2106 McCulloh St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Forbes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Married

6 (b) Name of husband or wife Morris Forbes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 16 1881

8. AGE: Years	Months	Days	If less than one day
65	11	19	hr. min.

9. Birthplace St. Mary's County, Md.
(Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Phillip Fauntleroy
13. Birthplace St. Mary's Co. Md.

MOTHER
14. Maiden Name Louisa Mason
15. Birthplace St. Mary's Co. Md.

16 (a) Informant Morris Forbes
(b) Address 2106 McCulloh St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 8, 1947 (month) (day) (year)
(c) Cemetery or crematory Leonardtown
Location St. Mary's Co. Md

18 (a) Funeral director Mrs. Hattie R. Williams
(b) Address 3 9 47 Edmonson Ave

19 MAR 8 1947 (Date rec'd by registrar) (b) Huntingtown, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4th 1947, at 4:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-25 1947, to 3-4 1947 and that I last saw her alive on 3-4-1947.

Immediate cause of death, Cerebral Hemorrhage — Duration 7 days

Due to Hypertensive Cardio-vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles L. Woodward M.D.
M. D.
Address 61 Harlem Ave Date signed 3-7-47

VS 150

G49364

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G49364

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3608 E. Pratt St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3608 E. Pratt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Caroline E. Huth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) ~~Single, married~~ widowed, or ~~divorced~~: Widowed

6 (b) Name of husband ~~or wife~~: Charles F. Huth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 2nd 1866

8. AGE: Years	Months	Days	If less than one day
81	0	2	hr. min.

9. Birthplace: Balto. Md.
(Town, county, and state)

10. Usual Occupation: At Home

11. Industry or business

FATHER
12. Name: George Scholl
13. Birthplace: Balto. Md.

MOTHER
14. Maiden Name: Mary Dess
15. Birthplace: Balto. Md.

16 (a) Informant: Hilda Lannon
(b) Address 1703 E. 25th St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 3/8/47 (month) (day) (year)
(c) ~~Cemetery or crematory~~: Holy Redeemer
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address 217 St. Paul St.

19 (a) MAR 8 - 1947 (Date ~~rec'd~~ by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 4th 1947, at 11 03 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-1-47 19 , to 3-4-47 19 , and that I last saw h~~e~~r alive on 3-4-47 19 .

Immediate cause of death	Duration
Arteriosclerotic Cardiovascular Disease	
Due to Generalized Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: John Carbentinis, M.D.
M. D.
Address 231 N. Gilmor St. Date signed 3-6-47

VS 150

G49365

BALTIMORE CITY HEALTH DEPARTMENT X ✓

CERTIFICATE OF DEATH 95c

G49365 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Garland
(If outside city or town limits, write RURAL and give town)
(d) Street No. Maple Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edgar Roy South

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~.
Male	White	Married

6 (b) Name of ~~husband~~ or wife Bertha Katherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23rd 1882

8. AGE: Years	Months	Days	If less than one day
64	9	13	hr. min.

9. Birthplace Eastern Shore of Md.
(Town, county, and state)

10. Usual Occupation Foreman

11. Industry or busine American Hammered Piston Ring Co.

FATHER
12. Name Millard South
13. Birthplace Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Earl Keys
(b) Address 4731 Amberley Ave.

17 (a) Burial (b) Date thereof 3/10/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director Williams Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) MAR 8 - 1947 (b) Huntington Williams Registrar
(Date rec'd by registrar)

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1947, at 11 15 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary thrombosis
Hypertrophy of heart
Due to Edema of lungs
Edema of brain
Other Conditions Tumor of spleen
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 3-6-47

X

G49366

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G49366

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: So Balto Gen Hosp
(d) Length of stay in hospital or inst. (~~yrs., months~~ days) 2
(e) Length of stay in Baltimore (~~yrs., months~~ days) 63

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town ~~Baltimore~~ Odenton
(If outside city or town limits, write RURAL and give town) ODENTON
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME albert Shipley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/7/84

8. AGE: Years 62 63 | Months 49 | Days | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER 12. Name Mountjoy Shipley

13. Birthplace Md.

MOTHER 14. Maiden Name ?

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-11-47 (month) (day) (year)

(c) Cemetery or crematory Savage Howard Co

Location Howard Co

18 (a) Funeral director Redgate Selby

(b) Address Randle Md

19 (a) MAR 8 - 1947 (Date rec'd by registrar) (b) Thurlington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1947 at 9:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 5 1947 to Mar 7 1947 and that I last saw h[illegible] alive on Mar 7 1947

Immediate cause of death	Duration
Resp Failure	
Due to Massive Intracranial hemorrhage	
Due to Hypertension + arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address So Balto Gen Hosp Date signed 3/8/47

X

G49367 b.c. J-12041

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

161a

Registered No. G49367

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves.
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 48 min
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - 11
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2902 Keswick Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Holmes

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-7-47

8. AGE: Years	Months	Days	If less than one day
			hr. 48 min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Ray P. Holmes, Jr.
13. Birthplace Md.

MOTHER
14. Maiden Name Helen N. Sheetz
15. Birthplace Md.

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-8-47 (month) (day) (year)
(c) Cemetery or crematory St Mary's
Location Hampden
18 (a) Funeral director Harold R. McNamara
(b) Address 4114 Falls Road
19 (a) MAR 8 - 1947 (Date rec'd by registrar) (b) Huntington-Williams Mortuary

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1947 at 1:14 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-7 1947 to 3-7 1947 and that I last saw h alive on 3-7 1947

Immediate cause of death Atelectasis — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Albert Blumberg M.D.
Address 230 E Lafayette Ave Date signed 3/8/47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49368

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G49368

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 607 Cumberland St
(c) Hospital or institution: 15 19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 607 Cumberland St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Lake

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widower

6 (b) Name of husband or wife Jane Lake
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25, 1871

8. AGE: Years	Months	Days	If less than one day
76	1	12	hr. min.

9. Birthplace Williamsport, Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name William H. Lake
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mr. Frederick Stevens
(b) Address 607 Cumberland St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-9-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 MAR 8 - 1947 Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6, 1947, at 7P M

21. I certify that death occurred on the date above stated, that I attended deceased from Dec 2 1946 to 3/6 1947 and that I last saw her alive on 3/6 1947

Immediate cause of death Hypertension Cardiac Renal — Duration 4 Mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. N. Hatcher

Address 1775 Park Date signed 3/9/47

VS 150

G49369

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G49369

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1029 Homewood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1029 Homewood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Catherine Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Henry J. Miller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 17, 1874

8. AGE: Years 73 | Months 0 | Days 19 | If less than one day hr. min.

9. Birthplace Harford Co Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John H. Kearney
13. Birthplace Md

MOTHER
14. Maiden Name Mary E Dalton
15. Birthplace Md

16 (a) Informant Mr Miller
(b) Address 1029 Homewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof MAR. 10, 1947 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 East Biddle St.

19 MAR 8 - 1947 (Date received by registrar) Huntington Williams, Md Registrar

VS 130

Dr Silberfeld

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 March 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1939 to 6 March 1947 and that I last saw h.e alive on 5 March 1947

Immediate cause of death	Duration
Coronary thrombosis	1 day
pulmonary edema	1 day
Due to Cardio-Vascular renal Disease	3 yrs
Due to	
Other Conditions arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel Silberfeld M. D.
Address 714 E. Preston Date signed 6 Mar 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

649370

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 649370

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 17 N. Amity St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 17 N. Amity St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary J. Hodges

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	Married

6 (b) Name of husband or wife William Hodges
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26, 1887

8. AGE: Years	Months	Days	If less than one day
59	2	10	hr. min.

9. Birthplace Lancaster Co., Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Jasper Johnson
13. Birthplace Virginia

MOTHER
14. Maiden Name Fannie Carter
15. Birthplace Lancaster Co. Va.

16 (a) Informant William Hodges
(b) Address 17 Amity St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 9 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Both could be registered) (b) Huntington for Williams, M.D. Registrar

MAR 8 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/6 1947, at 9:38 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/27 1947 to 3/6 1947 and that I last saw her alive on 3/6 1947.

Immediate cause of death	Duration
Acute Myocarditis	5 days
Due to Interstitial Nephritis and Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr. J. A. Duncan M. D.
Address 5 E. Madison St. Date signed 3/7 1947

G49371

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. G49371

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 822 N. Saratoga St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 822 N. Saratoga St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Brown

3 (b) If veteran, name war /

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 8, 1882

8. AGE: Years 65 64 | Months - | Days 25 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER 12. Name Arthur Brown
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Rachel Montgomery
15. Birthplace Aph. Co. Md.

16 (a) Informant Julia Caine
(b) Address 822 N. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 8 1947 (month) (day) (year)

(c) Cemetery or crematory W. Laurel Cem
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) MAR 8 - 1947 (Date rec'd by registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5, 1947 at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-1-1947 to 3-5-1947 and that I last saw h[illegible] alive on 3-4-1947.

Immediate cause of death	Duration
Chronic myocarditis	8 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm E. F. Campen M. D.
Address 639 N. Carey St. Date signed 3-7-47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correctly reported. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C49372

AB-106883

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

124 B

Registered No. C49372

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2417 St. Paul St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Dahoff

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-12-9952

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 16- 1882

8. AGE: Years	Months	Days	If less than one day
64	6	20	hr. min.

9. Birthplace Crisfield, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Harry McPherson
13. Birthplace D.C.

MOTHER
14. Maiden Name Margaret ?
15. Birthplace Va.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 8, 1947 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Baltimore, Md.

18 (a) Funeral director Joseph Fraase Inc
(b) Address 2013 Frankman St Apts

19 MAR 8 - 1947 (Date rec'd by registrar) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6- 1947, at 9.40PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-4- 1947 to 3-6- 1947, and that I last saw h. alive on 3-6- 1947.

Immediate cause of death	Duration
Hemorrhage from esophageal Varices	
Due to Cirrhosis of liver	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Robinson Jr M. D.
Address Bal City Hosp Date signed 3-7-47

VS 150

X

G49373

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 111c

G49373 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 307 S. Broadway
(c) Hospital or institution: ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ✓
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 307 S. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bertha (Bronislawa) Melnick

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Alexander Melnick
6 (c) If alive, give address deceased

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation House work
11. Industry or business

FATHER
12. Name unknown
13. Birthplace Poland

MOTHER
14. Maiden Name unknown
15. Birthplace Poland

16 (a) Informant Mrs. Jean Mitchell Daughter
(b) Address 4119 Marx ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-11-47 (month) (day) (year)
(c) Cemetery or crematory East Holy Redeemer
Location Balto City

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

MAR 8 - 1947 (Date rec'd by registrar)
(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION 345

20. DATE OF DEATH March 6 1947, at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 6 1947, to March 6 1947 and that I last saw h. alive on March 6 1947.

Immediate cause of death	Duration
PULMONARY EDEMA	3/6/47
Due to ACUTE CARDIAC (MYOCARDIAL) FAILURE	3/6/47
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation No NZ
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph F. Dzuga, M.D.
Address 209 N. Chester St Date signed 3/7/47
For F. H. Ober, by Howard J. Haslam, M.D.

VS 150

G49374

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

Registered No. G49374

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 603 E 37th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 603 E 37th St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Benjamin

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Cecelia Benjamin
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Jan 6- 1881

8. AGE: Years 66 | Months 2 | Days 1 | If less than one day ___ hr. ___ min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Church Sexton
11. Industry or business

FATHER
12. Name Samuel Benjamin
13. Birthplace Balto

MOTHER
14. Maiden Name Mary LeZerr
15. Birthplace Balto

16 (a) Informant Mrs Anna Benjamin
(b) Address 2229 E Preston

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 10 (month) (day) (year)
(c) Cemetery or crematory Baltimore City
Location

18 (a) Funeral director Ellis & Funeral Home
(b) Address 2008 Orleans St

19 (a) MAR 8 — 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7th 1947, at 1 30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 20 1946 to Mar 7 1947 and that I last saw him alive on Mar 7 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 days
Due to Chr Hypertension	3 yrs.
Due to Chr Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. G. Geyer M. D.
Address 1 E Melton Ave Date signed 3/7/47

VS 150

G49375

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93c

Registered No. G49375

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution:
University Hospital - W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 505 Archer Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** George Maddox

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-10-8042

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	married

6 (b) Name of husband or wife Shellie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1/22/1902

8. AGE: Years	Months	Days	If less than one day
45 4 4	1	15	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business George Maddox

FATHER 12. Name Charlotte

13. Birthplace Md

MOTHER 14. Maiden Name Charlotte Waters

15. Birthplace Md

16 (a) Informant Shellie Maddox

(b) Address 505 Archer Street

17 (a) Burial (b) Date thereof 3/9/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Monkton Md

18 (a) Funeral director Sarah L. Brown Jr.

(b) Address 1806 Montgomery St

19 (a) MAR 8 - 1947 Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-6-47 19 , at 5 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-3 1947 to 3-6- 1947 and that I last saw h. M. alive on 3-6-47 19

Immediate cause of death Congestive failure Duration
Rheumatic Cardiovascular
disease - uremia -
Due to Lupus subacute
yellow atrophy -
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George Y. Mansenberg M. D.
Address 16 Mount Rd Date signed 3-7-47

VS 150

X

G19376

G.M.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G19376

1. PLACE OF DEATH:

(a) Baltimore City, Maryland 4940 Eastern Ave.

(b) Street address

(c) Hospital or institution:

Baltimore City Hospitals 10 (11) Mos. 14 Days

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 16Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 519 Hamburg St. (Rear)

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME William Lloyd Parker

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) March 7,1928

8. AGE: Years	Months	Days	If less than one day
18	11	29	hr. min.

9. Birthplace N.C.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name William Anderson Parker

13. Birthplace N.C.

MOTHER

14. Maiden Name Mary Mitchell

15. Birthplace Va.

16 (a) Informant Records Baltomore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 3/11/47

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location A. A. Co. Md.

18 (a) Funeral director Isaac L. Brown Son

(b) Address 108 W Monty omery St

19 (a) MAR 8 1947 (b) Huntington Williams M.D.

(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1947, at 8.10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-22 1946, to 3-6 1947, and that I last saw him alive on 3-6 1947.

	Duration
Immediate cause of death: Pulmonary Tuberculosis, Far-Adv.	1 year
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature William J. Hunt M.D.

Address Balt. City Hosp. Date signed 3-7-47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49377

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G49377

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 815 Plum Alley
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs.) mos., or days 30

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto City (If outside city or town limits, write RURAL and give town)
(d) Street No. 815 Plum Alley (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oliver Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Georgia Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/15/1898

8. AGE: Years 48 | Months 11 | Days 9 | If less than one day hr. min. 21

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Sammie Johnson

13. Birthplace Md

MOTHER 14. Maiden Name Eliza Howard

15. Birthplace Md

16 (a) Informant Lottie Berry

(b) Address 815 Plum alley

17 (a) Burial (b) Date thereof 3/9/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Calvert Co, Md

Location Md

18 (a) Funeral director Isaac L Brown & Son

(b) Address 108 W Montgomery St

MAR 8 - 1947 (a) (b) Funeral Home Williamsport, Md
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/6/47 19 , at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-4- 1947 to 3-5- 1947 and that I last saw him alive on 3-5- 1947

Immediate cause of death Tuberculosis Pulmonary — Duration

Due to Pulmonary Tuberculosis

Due to

Other Conditions Cardiac Failure

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm Garfield

Address 182 Eutaw St Date signed 3/7/47

VS 150

Dr. Kirby
110 E. North Avenue

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G19378

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2210 Erdman Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2210 Erdman Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick C. Koehler

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Mary H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1, 1866

8. AGE: Years	Months	Days	If less than one day
80	10	5	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Ambrose Koehler
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace Germany

16 (a) Informant Mrs. Mary H. Koehler
(b) Address 2210 Erdman Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/10/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (b) Huntington Williams M.D.
(Registrar)
MAR 8 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 6th, 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1946 to Mar 5 1947 and that I last saw h[illegible] alive on Mar 6 1947.

Immediate cause of death	Duration
Adenocarcinoma Sigmoid colon type	
Due to Lower Jaw -	
Due to Metastases	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None Radium 3/47
Major findings of operation: None
of autopsy: ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frances J. Kirby M.D.
Address 110 E. North Ave Date signed 3/7/47

X

G49379

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G49379

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2747 Washington Blvd
(c) Hospital or institution: Morrell Pk. Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo. 11da.
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2747 Washington Blvd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FREDERICK FERDINAND SCHNEIDER

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Berta Schneider
6 (c) If alive, give age: 35 years

7. Birth date of deceased (mo., day, yr.): July 18, 1876

8. AGE: Years: 70 | Months: 7 | Days: 15 | If less than one day: hr. min.

9. Birthplace: Vienna (Town, county, and state)
10. Usual Occupation: German Consul
11. Industry or business

FATHER
12. Name: Joseph Schneider
13. Birthplace: Vienna

MOTHER
14. Maiden Name: Magdalena Finn
15. Birthplace: Hungary

16 (a) Informant: Mrs. Berta Schneider
(b) Address: 301 Stoneleigh Rd

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 3/8/47 (month) (day) (year)
(c) Cemetery or crematory: Greenmount
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS,
(b) Address: NORTH AVE. & BROADWAY

19 (a) MAR 8 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION A. M.

20. DATE OF DEATH March 5 1947, at 11.25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 18 1947, to March 4 1947 and that I last saw him alive on March 4 1947.

	Duration
Immediate cause of death: Cardio Resp. failure	Immediate
Due to: Cerebral Hemorrhage	Dec. 25-46
Due to: Cardio Vascular disease Hypertension	?
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? INC
(e) Means of injury

23. Signature: Charles Tammaro M. D.
Address: 910 W. Lombard Date signed: Mar. 6/47

VS 150

G49380

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G49380 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Santoga Sts.
(c) Hospital or institution: Mercy Hospital 9 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1211 E. North Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Conrad Himmer (CONRAD HIMMER, Sr.)

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife: Minnie Himmer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 3, 1886

8. AGE: Years	Months	Days	If less than one day
60	6	3	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Printer
11. Industry or business

FATHER
12. Name George Himmer
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Henriette Lehnidt
15. Birthplace Europe

16 (a) Informant Minnie Himmer
(b) Address 1211 E. North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-10-47 (month) (day) (year)
(c) Cemetery or crematory MT. OLIVET
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 MAR 8 - 1947 (Date rec'd by reg.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1947 at 9.40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/2 1947 to 3/6 1947, and that I last saw him alive on 3/6 1947

Immediate cause of death: Resp. failure — Duration

Due to: Coronary insuff.

Due to:

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature August Kiel M. D.
Address Mercy Hosp. Date signed 3/6/47

VS 150

G49381

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G49381

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 631 LEE Street
(c) Hospital or institution: ~~Y~~
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 9 Months

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town BALTimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 631 LEE Street (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Edward TORNEY

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: MALE | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife Rebecca Torney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 77 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Calvert County, MARYLAND (Town, county, and state)

10. Usual Occupation Oysterman

11. Industry or business

FATHER
12. Name Major TORNEY
13. Birthplace Calvert County

MOTHER
14. Maiden Name ELIZA Phillips
15. Birthplace Calvert County

16 (a) Informant Mr. BENSON TORNEY
(b) Address 301 N. Mount Street

17 (a) ... (Burial, cremation, or removal) (b) Date thereof 8 (month) 4 (day) 7 (year)
(c) Cemetery or crematory Calvert Co. Md.
Location

18 (a) Funeral director Walter B. Lang
(b) Address 18 E. Mt. Royal Ave. Huntington-Williams, Inc.

19 (a) MAR 8 - 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1947, at 11:00 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 13 1947, to March 4, 1947, and that I last saw him alive on March 3 1947.

	Duration
Immediate cause of death: Coronary Occlusion	Day
Due to ARTERIOSCLEROSIS Obliterans	several Months
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard H. Hunt M. D.
Address 1631 W. Franklin St. Date signed 3-5-47

VS 3

X

G49382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G49382

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen'l
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 213 Otterbein (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amos Bennett

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-06-6047

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years 50 | Months | Days | If less than one day hr. min.

9. Birthplace West Indians Island (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace Unknown

16 (a) Informant Mary Easton
(b) Address Hazel Reformation

17 (a) (Burial, cremation, or removal) (b) Date thereof 3 8 47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calay
Location Baltimore

18 (a) Funeral director Plato D. Driggs
(b) Address 139 W. Maryland St. Baltimore, Md

19 (a) MAR 8 - 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/3/47 19 at 6:25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John L. D'Arco M.D. Medical Examiner.
Date signed 3/4/47

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49383

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

Registered No. G49383

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 410 Rosebank Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 410 Rosebank Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ROBERT McDOWELL

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Blanche H. McDowell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 8, 1882

8. AGE: Years	Months	Days	If less than one day
64	6	28	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Auditor
11. Industry or business U. S. F. & G. Co.

FATHER
12. Name Hamilton McDowell
13. Birthplace Ireland

MOTHER
14. Maiden Name Lollie Ensor
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Blanche H. McDowell
(b) Address 410 Rosebank Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAR 8 - 1947 (Date rec'd by registrar)
(b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6, 1947, at 1:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1946, to Mar. 1947, and that I last saw him alive on 5 Mar. 1947.

Immediate cause of death: Pulmonary Carcinoma with vertebral metastasis — Duration: 5 mos.
Due to
Due to
Other Conditions Pathological fracture, r. hip
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. H. Kammer, Jr. M.D.
Address 501 Sheridan Ave. Date signed 3-8-47

G49384

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G49384 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 811 S. Ann Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 811 S. Ann Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME WALERIAN CHOJNOWSKI

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Aleksandra
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/27/72

8. AGE: Years	Months	Days	If less than one day
74	3	8	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Stanislaus Chojnowski
13. Birthplace Poland

MOTHER
14. Maiden Name ------ Stypukowski
15. Birthplace Poland

16 (a) Informant Miss Anna Chojnowski
(b) Address 811 S. Ann Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/10/47 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Road

18 (a) Funeral director M. J. Sadowski & Sons
(b) Address 1808 Eastern Avenue

19 (a) Mar 8 - 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1947 at 8:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1947 to March 5 1947 and that I last saw h[illegible] alive on March 5 1947.

Immediate cause of death	Duration
Coronary Thrombosis	3/4/47
Due to Arterio-Sclerosis & Heart disease	6/1944
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Grauer M. D.
Address 801 Cathedral St. Date signed 3/10/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49385

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 5162

Registered No. G49385

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + Saratoga Sts
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13d.
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Nowe
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1921 McCulloh St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Willis Chandler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Black	Seper.

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 8 1872

8. AGE: Years	Months	Days	If less than one day
74 75	23	29	hr. min.

9. Birthplace Rocks boro N. Car.
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business ?

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Self.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/10/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto. Md.

18 (a) Funeral director Wm. L. Tolbert Son Jr
(b) Address 1701 McCulloh St.

19 (a) MAR 8 1947 (Date rec'd by registrar) (b) Huntington Willis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 6 1947, at 12 15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-21 1947 to 3-6 1947 and that I last saw h/his alive on 3-5 1947

	Duration
Immediate cause of death Resp. Failure	10 m in
Due to Metastases to Lung	6 mon.
Due to Carcinoma of Prostate	2+ yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William D. Gentry, Jr. M.D.

Address Mercy Hosp. Date signed 3-1-47

VS 150

G49386
502620

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G49386
Registered No.

55 P

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County
(c) City or town Milton Pennsylvania
(If outside city or town limits, write RURAL and give town)
(d) Street No. 626 Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ralph S. Brantigam

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) 10-24-1891

8. AGE: Years	Months	Days	If less than one day
55 54	-4	-15	hr. min.

9. Birthplace Pa
(Town, county, and state)

10. Usual Occupation Merchant
11. Industry or business Hardware

FATHER
12. Name Wm. H. Brantigam
13. Birthplace Pa

MOTHER
14. Maiden Name Emma Algert
15. Birthplace Pa

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof March 8 1947 (month) (day) (year)
(c) Cemetery or crematory Harmony Cemetery
Location Milton, Penna

18 (a) Funeral director Wm. Seebold
(b) Address 1217 St Paul St Balto Md

19 (a) (Date rec'd by registrar) (b) Registrar

APR 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 8 1947 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 13 1946 to Mar. 8 1947 and that I last saw h living alive on Mar 8 1947.

Immediate cause of death Cachexia

Due to Squamous degeneration of Paget's disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10-15-46

Major findings of operation: Sarcoma of spine

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C W Burkland M. D.
Address Johns Hopkins Hospital Date signed 3-8-47

X

G49387 Folks

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46a

G49387 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State S C. (b) County
(c) City or town Columbia (If outside city or town limits, write RURAL and give town)
(d) Street No. 204½ Sumter St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Oscar Folks Folks

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Dollie Mae
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-28-1897

8. AGE: Years 49 | Months 5 | Days 11/10 | If less than one day hr. min.

9. Birthplace Ala. (Town, county, and state)

10. Usual Occupation Furniture Salesman

11. Industry or business

FATHER
12. Name John Henry Folks (Folks)
13. Birthplace Ala.

MOTHER
14. Maiden Name Mamie Whitman
15. Birthplace Ala

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3-8-47 (month) (day) (year)
(c) Cemetery or crematory
Location Columbia S. C.

18 (a) Funeral director Hamilton Fuhrman & Sons
(b) Address Baltimore Md

19 (a) MAR 8 1947 (Date rec'd by registrar) (b) Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1947 at 8:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 28 1947 to Mar 8 1947 and that I last saw him alive on Mar 8 1947

Immediate cause of death: Postoperative massive pneumothorax — Duration

Due to: Operation for carcinoma of esophagus

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation March 7th 1947

Major findings of operation: Large carcinoma of lower third + mid third of esophagus

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard V. Clay

Address Johns Hopkins Hosp Date signed 2/12/47

G49388

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G49388
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1216 Cuisgnith St
(c) Hospital or institution:
10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1216 Cuisgnith St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Mc-Cabe Waldner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	Married

6 (b) Name of ~~husband~~ or wife George Waldner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 13. 1890

8. AGE: Years	Months	Days	If less than one day
57	1	23	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation
11. Industry or business Housewife

FATHER
12. Name James F. McCabe
13. Birthplace Baltimore

MOTHER
14. Maiden Name Rose Doyle
15. Birthplace Baltimore

16 (a) Informant George Waldner
(b) Address 1216 Cuisgnith St

17 (a) Burial (b) Date thereof March 10 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location Old Frederick Road

18 (a) Funeral director John C Moran
(b) Address 3000 E Baltimore St

19 (a) 1947 (b)
(Date rec'd by registrar) Jos. Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/5 1947 to 3/7 1947 and that I last saw h-e-r alive on 2/5 1947

Immediate cause of death	Duration
Cerebral Hemorrhage	Sudden
Due to Hypertension	5 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Friedman M.D.
Address 120 E. Fenton St Date signed 3/7/47

VS 150

G49389

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G49389 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5323 Wilton Heights Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-18
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5323 Wilton Heights Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary L. Newton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Lewis S. Newton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 10, 1869

8. AGE: Years 78 | Months – | Days 25 27 | If less than one day hr. min.

9. Birthplace Norfolk, Va.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John Peil
13. Birthplace North Carolina

MOTHER
14. Maiden Name Mary E. Benthal
15. Birthplace Norfolk, Va.

16 (a) Informant Mrs. Beulah Trappe
(b) Address 5325 Wilton Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 10, 1947 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Willis L. Amonett
(b) Address 4510 Liberty Heights Ave.

19 (a) (Date rec'd by registrar) MAR 9 1947 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1947, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946 to March 7 1947, and that I last saw her alive on March 3 1947

	Duration
Immediate cause of death: Decubitus ulcers & resulting toxemia	2 Months.
Due to: Arteriosclerosis	20 years
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Egbert H. Mortimer M. D.
Address 2706 St. Paul St. Date signed

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49390

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G49390 Registered No. 94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2511 Queen Anne Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2511 Queen Anne Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laurence Marcus

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years 53 | Months | Days | If less than one day hr. min.

9. Birthplace unknown (Town, county, state)

10. Usual Occupation retired officer U.S.A.

11. Industry or business

FATHER 12. Name unknown

13. Birthplace unknown

MOTHER 14. Maiden Name Olga

15. Birthplace unknown

16 (a) Informant Jeanne Abraynson

(b) Address 4107 Wentworth Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-10-47 (month) (day) (year)

(c) Cemetery or crematory Arlington Nat. Cem.

Location Alex. Va.

18 (a) Funeral director Jack Lewis Inc

(b) Address 1432 E. Baltimore St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR. 7 1947, at 10A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-7- 1947 to 3-7- 1947 and that I last saw him alive on 3-7- 1947

Immediate cause of death: ACUTE CORONARY OCCLUSION — Duration: 8 yrs.

Due to: CORONARY SCLEROSIS

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert H. Hunt Jr. M.D.

Address 1801 E. Fayette Pl Date signed 3/7/47

Howard J. Andersen, M.D. X

VS 150

G49391

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

G49391 Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNPADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4404 Maine Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4404 Maine Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME David N. Finck
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Mollie
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1896
8. AGE: Years 51 | Months | Days | If less than one day hr. min.
9. Birthplace Newyork (Town, county, and state)
10. Usual Occupation Electrical Engineer
11. Industry or business

FATHER 12. Name Henry
13. Birthplace Poland
MOTHER 14. Maiden Name Rose
15. Birthplace Poland

16 (a) Informant Mollie Finck
(b) Address 4404 Maine Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-9-47 (month) (day) (year)
(c) Cemetery or crematory Arlington Cem
Location Rogers Ave
18 (a) Funeral director Jack Lewis Inc
(b) Address 429 E Balto St Baltimore, Md
19 (a) MAR 9 1947 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-8- 1947; at 5A M
21. I certify that death occurred on the date above stated; that I attended deceased from 10/3 1945 to 3/7 1947. and that I last saw h/him alive on 3/7 1947.

Immediate cause of death Carcinoma of Rectum — Duration 16 mos.
Due to
Due to
Other Conditions None
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Louis Blum, M.D.
Address 2310 Eutaw Place Date signed 3/8/47

VS 150

X -

G49392

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G49392 Registered No. 194a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3904 Springdale Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Fannie Stalman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 6 - 1897

8. AGE: Years 49 | Months 4 | Days - | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Bookkeeper

11. Industry or business

FATHER 12. Name David Russia
13. Birthplace

MOTHER 14. Maiden Name Rebecca
15. Birthplace Russia

16 (a) Informant Rebecca Stalman
(b) Address 3904 Springdale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-9-47 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Cem
Location Jack Lewin Inc
18 (a) Funeral director 1429 E Balto St
(b) Address
19 (a) MAR 10 - 1947 (Date rec'd by registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1947 at 11:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 3 1947 to 8 1947 and that I last saw h[illegible] alive on March 8 1947

Immediate cause of death Myocardial insufficiency — Duration

Due to Recent myocardial infarction, Ant. wall L.V. Septum

Due to Occlusion of left anterior coronary artery (recent)

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Heinz Beisinger
Address Sinai Hospital Date signed 3/8/47

V S 150

X

G49393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55B

G49393 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St & Rutland Av
(c) Hospital or institution: Sinai Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 41yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
City or town 2538 E Balto St
(If outside city or town limits, write RURAL and give town)
(d) Street No. Balto
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Toney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: House

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1886

8. AGE: Years 61 | Months | Days | If less than one day hr. min.

9. Birthplace Riga (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Max —
13. Birthplace Riga —

MOTHER
14. Maiden Name Letta
15. Birthplace Riga

16 (a) Informant Rose Toney
(b) Address 2538 E. Balto. St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-9-47 (month) (day) (year)
(c) Cemetery or crematory Helgus Mt Carmel
Location

18 (a) Funeral director Jacob Levin Inc
(b) Address 1421 E. Balto St

19 (a) JAN 9 1947 (Date rec'd by registrar) (b) Clayton Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8th 1947, at 2.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4th 1947, to March 7th 1947 and that I last saw h[illegible] alive on 3/7th 1947

Immediate cause of death: Sarcoma of Rectum — Duration 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. J. Faulkner M. D.
Address 100 N. Mellon Date signed 3/10/47

VS 150

G49394

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G49394 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 720 N. Gay St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 D
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 720 N. Gay St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Saul White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 26th 1896

8. AGE: Years 50 | Months 6 | Days 11 | If less than one day hr. min.

9. Birthplace Jamestown S. C. (town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Matthew White

13. Birthplace S. C

MOTHER 14. Maiden Name Mary Ann Bennett

15. Birthplace S. C

16 (a) Informant Anna Smalls

(b) Address 952 Park Ave. New York City

17 (a) Burial (b) Date thereof 3 9th 1947 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Old Emanuel

Location Jamestown S. C.

18 (a) Funeral director Robinson & Inamis & Wright

(b) Address 727 Pennsylvania Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 9 - 1947

(SEE BACK)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-6- 1947 at 5:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-24- 1947 to 3-6- 1947 and that I last saw h/m alive on 3-6- 1947

Immediate cause of death Cardiac & Respiratory failure — Duration

Due to Lobar Pneumonia — 10 Days

Due to acute Dilatation — 1

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury Harmon

23. Signature Louis E. Dunn M. D.

Address 2340 Madison Date signed 3-8-47

G49395 WD 5500

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 138

G49395
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. ~~[illegible]~~ 1027 N. Broadway (Number and street or location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lloyd ~~Rogers~~ Rodgers
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced
Male	Black	Married

6 (b) Name of husband or wife Susie ~~Rogers~~ Rodgers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-26-1897

8. AGE: Years	Months	Days	If less than one day
50	1	10	hr. min.

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ? ?
13. Birthplace N. C. ?

MOTHER
14. Maiden Name ? ?
15. Birthplace ? N. C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-10th 1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Pk
Location Balto. County

18 (a) Funeral director Belmont Mangus & Horgan
(b) Address 729 Cathedral St

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 5 1947 134 Hunting for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 5th 1947, at 6 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 4 1947, to Mar 5 1947 and that I last saw him alive on Mar. 5 1947.

Immediate cause of death	Duration
Tbc pneumonia	
Due to	
Due to	
Other Conditions Diabetes Mellitus	1

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E. Mason
Address Johns Hopkins Hosp. Date signed 6th Mar 47 D.

G49396

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G49396 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 Cold Spring Lane
(c) Hospital or institution: Cold Spring Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 months 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) all

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto city
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 Cold Spring Lane (If rural give location)
(e) Citizen of foreign country? unknown (Yes or No)
If yes, name country

3 (a) FULL NAME George H. Smith

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
M.	W.	W

6 (b) Name of ~~husband~~ or wife Catherine M. Young
6 (c) If alive, give age Years

7. Birth date of deceased (mo., day, yr.) Sept. 10 - 1855

8. AGE: Years	Months	Days	If less than one day
91 92	5	26	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Conrad Smith
13. Birthplace Central ~~Germany~~ Europe

MOTHER
14. Maiden Name ~~Mary~~ [illegible]
15. Birthplace Europe

16 (a) Informant Catherine M. Smith
(b) Address 2101 Cold Spring Lane

17 (a) Burial (b) Date thereof 3/10/47 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director H. B. Cunningham Son
(b) Address 2924 Edmondson ave

19 (a) [illegible] Washington Williams, Registrar
(Date filed by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1947 at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1941 to March 6 1942 and that I last saw h~~im~~ alive on March 5 1947.

Immediate cause of death	Duration
DIABETIC GANGRENE BOTH LEGS -	6 mos -
Due to DIABETES MELLITUS	10 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Norman L. Klemm
Address 3803 Edmondson Ave Date signed 3/7/47 M. D.

X

G49397

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G49397

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1933 Jefferson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1933 Jefferson St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Hattie Moore Walker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-26-1888

8. AGE: Years	Months	Days	If less than one day
58	6	10	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation domestic

11. Industry or business

FATHER 12. Name James Henson

13. Birthplace ? Md

MOTHER 14. Maiden Name Susana

15. Birthplace ? Md

16 (a) Informant Ada Mitchell

(b) Address 1933 Jefferson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 9 47 (month) (day) (year)

(c) Cemetery or crematory Arch Rites Memorial Park

Location Md

18 (a) Funeral director Rayner Sanders

(b) Address 1412 Eutaw Pl. Phone Lafayette, MD St.

19 (a) MAR 9 1947 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/5 1947, at 9:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/14 1947 to 3/5 1947 and that I last saw h[illegible] alive on 3/5 1947.

Immediate cause of death	Duration
Coronary occlusion	3 Days
Due to hypertensive cardio-renal disease	
Due to	
Other Conditions arthritis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rayner Browne M.D.

Address 1500 E. Mad. St Date signed 3/6/47

Rayner Browne X

G49398

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G49398

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1343 Division St.
(c) Hospital or institution:

17

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1343 Division St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Whittington

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race Col

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-6-99

8. AGE: Years 48 | Months - | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name James Whittington
13. Birthplace Va.

MOTHER
14. Maiden Name Sarah Bean
15. Birthplace Md.

16 (a) Informant Sarah Whittington
(b) Address 1343 Division St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-10-47 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. Co.

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) 3-7-1947 (Date rec'd by registrar) (b) Whittington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-7- 1947, at 0730 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-25- 1947 to 3-7- 1947 and that I last saw her alive on 3-6- 1947.

Immediate cause of death Hypertensive Heart — Duration 6 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George C. Page
Address 1516 N. Mountbat (17) Date signed M. 3 D. 7

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49399

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G49399

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 824 Eastern Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 824 Eastern Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louise A. Bacigalupo

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: Louis Bacigalupo
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18 1875

8. AGE: Years	Months	Days	If less than one day
71	8	17/19	hr. min.

9. Birthplace: Baltimore Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business: Home

FATHER
12. Name: John Cuneo
13. Birthplace: Italy

MOTHER
14. Maiden Name: Clara Rettaliata
15. Birthplace: Italy

16 (a) Informant: Louis Bacigalupo (Husband)
(b) Address: 824 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 10/47 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Rd. Baltimore Md.

18 (a) Funeral director: Frank Della Rose
(b) Address: 12 N. Morley St.

19 (a) (Date received by registrar) (b) Registrar

MAR 9 1947 Harry Lee Williams, M.D.

RS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1947, at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 15 1947 to Mar. 7 1947 and that I last saw h[er] alive on Mar. 7 1947

	Duration
Immediate cause of death: Uremia	7
Due to: Cardio Vascular Nephritis	?
Due to: Arteriosclerosis	?
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Jos L. Volpe
Address 1732 N. Broadway Date signed 3/8/47

X

G49100

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G49100 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 42 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2833 Cold Spring Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VINCENT DE POLA ~~(DI PAULA)~~ De Paola

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Anna Miller DePaola

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22, 1908

8. AGE: Years 39 | Months 0 | Days 13 | If less than one day hr. min.

9. Birthplace Atlantic City, N. J.
(Town, county, and state)

10. Usual Occupation Counter

11. Industry or business Sparrows Point Ship Yard

FATHER
12. Name Samuel De Paola
13. Birthplace Fla.

MOTHER
14. Maiden Name Vista Weiland
15. Birthplace Ala.

16 (a) Informant Anna Miller De Paola
(b) Address 2833 Cold Spring Lane

17 (a) Burial (b) Date thereof 3-10-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Lorenz Byers
(b) Address 5005 Pulaski Highway

19 (a) MAR 9 - 1947 (b)
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7, 1947, at 6:20 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull,
Fractured second and third vertebrae

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was ~~primary~~ ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-5-47 at 10:05 A. M.
(b) Where did injury occur? Sparrows Pt. Shipyard
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Fell from scaffold

23. Signature Earl L Ring M.D.
Medical Examiner.
Date signed 3/7/47

G49101

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G49101 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution:
Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9d.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 937 N Calvert St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harold Davies

3 (b) If veteran, name war ?
3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31, 1903

8. AGE: Years	Months	Days	If less than one day
43	5	10	hr. min.

9. Birthplace Balto Md.
(Town, county, and state)
10. Usual Occupation ?
11. Industry or business

FATHER
12. Name Gomer Davies
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Sarah Lloyd
15. Birthplace Wales

16 (a) Informant Self
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/12/47 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore Md

18 (a) Funeral director Wilson Funeral Home
(b) Address 1247 E Fort Ave

19 MAR 10 1947 (Date rec'd by registrar) Signature for Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1947 at 1:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-24 1947 to 3-9 1947 and that I last saw h[illegible] alive on 3-9 1947

Immediate cause of death Resp. Fail — Duration 3 days

Due to Carcinoma of Liver — Duration ? yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 2-6-47

Major findings of operation: Ca. of Liver

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William P. Canby Jr. M. D.
Address Mercy Hosp Date signed 3-9-47

VS 150

G49103 R19103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1905 Frederick Ave
(c) Hospital or institution: 70

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1905 Frederick Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Ann LeBon

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Charles L
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 8 1854

8. AGE: Years: 93 | Months: 1 | Days: 29 | If less than one day: hr. min.

9. Birthplace La Cate Belgium
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name (Unknown) Courseoux
13. Birthplace Belgium

MOTHER
14. Maiden Name Unknown
15. Birthplace Belgium

16 (a) Informant Alphonse LeBon
(b) Address 1905 Frederick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/10/47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Nelson & Son
(b) Address 1204 Cove St

19 (a) MAR 10 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1947 at 11:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 7 1947 to March 7 1947 and that I last saw her alive on 3/7 1947.

Immediate cause of death Uraemia
Infected cardiac valve
Disease — Duration: 6 mos

Due to — Duration:

Due to — Duration:

Other Conditions — Duration:
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller
Address 2030 Eutaw Date signed 3/10/47 M.D.

aw X

G49103 BL# G68393

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 119a

G49103 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Chas + Caroline
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1927 Casadell Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Richard L. Sweet

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 11/5/46

8. AGE: Years	Months	Days	If less than one day
	4	3	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER 12. Name George M. Sweet
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Elizabeth Ditty
15. Birthplace Balto. Md.

16 (a) Informant Geo. M. Sweet
(b) Address 1927 Casadell Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/10/47 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location a.a. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1317 St. Paul St.

MAR 10 1947 (Date received by registrar) (b) Huntington Williams III

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/5/1947, at 6 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/5/1947 to 3/8/1947, and that I last saw him alive on 3/5/1947

Immediate cause of death	Duration
Cardiac Failure	
Due to Atelectasis	
Due to	
Other Conditions Diarrhea	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard A. Young, M.D.
Address St. Josephs Hosp. Date signed 3/8/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

G49104

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43a

Registered No. G49104

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2524 HARFORD Rd.
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2524 HARFORD Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME GEORGE EDWARD GLISS

3 (b) If veteran, name war: NONE

3 (c) Social Security Account No. 215-10-2168

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: HELEN S.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 11, 1904

8. AGE: Years 42 Months 6 Days 27 If less than one day hr. min.

9. Birthplace BALTIMORE, Md. (Town, county, and state)

10. Usual Occupation AUTO MECHANIC

11. Industry or business FULTON GRAND LAUNDRY

FATHER
12. Name GEORGE GLISS
13. Birthplace Md.

MOTHER
14. Maiden Name EMMA L. SCHINDHELM
15. Birthplace Md.

16 (a) Informant HELEN S. GLISS
(b) Address 2524 HARFORD Rd.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAR. 13, 1947 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location BALTIMORE, Md.

18 (a) Funeral director WILLIAM COOK INC.
(b) Address 1217 ST. PAUL ST.

19 (a) 3-10-1947 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mardi 9 1947, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to March 9 1947 and that I last saw [illegible] alive on March 9 1947

Immediate cause of death: a Cerebral Hemorrhage — Duration 8 hrs

Due to: b High blood pressure — 8 yrs

Due to: c

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address 2558 Harford Date signed 3-10-47

VS 180

G19105 BC. G 72486

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161 B

Registered No. G19105

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green Sts.
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. ~~Lombard & Green Sts~~ 26 Hanover Lane (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Boy "B" Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Colored	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/5/47

8. AGE: Years	Months	Days	If less than one day
		5	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Eugene Jackson
13. Birthplace Md

MOTHER 14. Maiden Name Harriet Smith
15. Birthplace Md

16 (a) Informant Harriet Jackson
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

University Medical School MAR 7 1947
Commissioner of Health
MAR 10 1947 (Date rec'd by Registrar) Huntington Williams M.D.

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-5- 1947, at 8P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-5 1947 to 3-5 1947, and that I last saw him alive on 3-5 1947.

Immediate cause of death Cardiac failure

Due to Toxemia

Due to Post Septicemia complications

Other Conditions Icterus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. H. Vaughan Jr. M.D.
Address Univ Hospital Date signed 3-5-47

G49106 BCH G71907

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G49106 Registered No. 226½

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Gaine Sts
(c) Hospital or institution:
Univ. Hosp 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 da
(e) Length of stay in Baltimore (yrs., mos., or days) 9 da

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1814 Riggs Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby boy Spence

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/22/47

8. AGE: Years	Months	Days	If less than one day
		9	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name James Spence
13. Birthplace Va.

MOTHER 14. Maiden Name Fannie Parker
15. Birthplace Va.

16 (a) Informant Mother
(b) Address

17 (a) (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School MAR 7 1947

18 (a) Funeral director
(b) Address Commissioner of Health

19 MAR 10 1947 Huntington Williams, M.D.
(Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-3 1947 at 11:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/22 1947 to 3/3 1947 and that I last saw him alive on 3/3 1947

Immediate cause of death Respiratory Failure — Duration
Due to Prematurity
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. Maylad Jr. M. D.
Address Municipal Hospital

G49107

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G49107 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Baltimore 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 816½ W. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Marcela Adamaitis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Frank Adamaitis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1887

8. AGE: Years 60 58 | Months | Days | If less than one day hr. min.

9. Birthplace Lithuania
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name M. Balchaitis
13. Birthplace Lithuania

MOTHER
14. Maiden Name ?
15. Birthplace Lithuania

16 (a) Informant Albert Adamaitis - Son
(b) Address 816½ W Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 10-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Belair Rd

18 (a) Funeral director Joseph Czarnecka Jr.
(b) Address 604 Washington Blvd

MAR 10 1947 (Date received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1947; at 1:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1946 to Mar 6 1947, and that I last saw h[illegible] alive on Mar 6 1947.

	Duration
Immediate cause of death: Coronary Occlusion	
Due to: Hypertension and Arteriosclerotic Heart Disease	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature: Thomas M. Hutchins M. D.
Address St. Paul Hospital Date signed March 10 1947

VS 150

G19408

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

462

Registered No. G19408

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2719-Stelmans Rd.
(c) Hospital or institution: Cherry Hill Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Cherry Hill
(If outside city or town limits, write RURAL and give county)
(d) Street No. 2719-Stelmans Rd.
(If rural, give location)
(e) Citizen of foreign country? (Apt. 213) (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel Gamble

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Fem. | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Lewis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 189[illegible]

8. AGE: Years 56 | Months 9 | Days | If less than one day: hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Chas. Wilson
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Mary E. Baker
15. Birthplace Balto. Md.

16 (a) Informant Harry Grey
(b) Address 1424 Aliceton St.

17 (a) Burial (b) Date thereof 3/11/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Lub Cem
Location W. Halstead

18 (a) Funeral director W. Edmund Hill
(b) Address 918- Edmund Hill

MAR 10 1947 Huntington-Williams Corp.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6, 1947, at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 3 1947 to [illegible] 19[illegible], and that I last saw h[illegible] alive on March 3 1947.

Immediate cause of death Emaciation — Duration

Due to Cancer — 2 days

Due to — over

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Karl Trompeter M.D.

Address 623 E. N. Ave. Date signed 3-7-47

VS 150

G49109

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

G49109 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 809 N. Wolfe st.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 809 N Wolfe St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mary T. Anderson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or Race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30-1871

8. AGE: Years 75 | Months 7 8 | Days 8 | If less than one day ____hr. ____min.

9. Birthplace Washington D. C.
(Town, county, and state)

10. Usual Occupation Housework
11. Industry or business Home

FATHER
12. Name Morgan McGeneray
13. Birthplace Wash. D. C.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs Stella Bergan
(b) Address 809 N Wolfe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 11/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director Geo M. Fenwick & Son
(b) Address 811 N Wolfe St

19 (a) MAR 10 1947 (Date rec'd by registrar) (b) Interring for Williams 47

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 7 1947 at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/2 1946 to 3/7 1947, and that I last saw h[illegible] alive on 3/5 1947

Immediate cause of death: Arteriosclerosis — Duration: —
Due to: Cerebral hemorrhage — Duration: Dec 1946
Due to: Hypertension — Duration: 2 yrs.
Due to: Myocardial degeneration — Duration: 2 yrs.

Other Conditions:
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence:
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Louis T. Kilmer
Address 2623 E. Monument Date signed 3/8/47

G19110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46F

Registered No. G19110

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla. (b) County
(c) City or town Miami
(If outside city or town limits, write RURAL and give town)
(d) Street No. Route 2 Box 575 (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Coons, Hugh Bernard

3 (b) If veteran, name war

3 (c) Social Security Account No. 265-09-7122

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Sep.

6 (b) Name of husband or wife Rachel Bearder Coons
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1889

8. AGE: Years	Months	Days	If less than one day
57	2	10 8	hr. min.

9. Birthplace Cedar Keys, Fla. (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business Seafarer

FATHER
12. Name Eugene Coons
13. Birthplace Tenn.

MOTHER
14. Maiden Name Sarah Davis
15. Birthplace Fla.

16 (a) Informant US Marine Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-10-47 (month) (day) (year)
(c) Cemetery Loudon Cemetery
Location 582 York Rd

18 (a) Funeral director Odell Funeral Home
(b) Address 4423 E. 25th St. Huntington, West Va.

19 MAR TO 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1947; at 8:30A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 13 1947 to Mar. 5 1947 and that I last saw him alive on Mar. 5 1947.

Immediate cause of death Cerebral embolism

Duration Less than 1 wk.

Due to perforated duodenal ulcer

Due to

Other Conditions Disseminated embolism of Liver; acute hepatoma

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. B. Springer M. D.
Address U. S. Marine Hospital Date signed 3-8-47

VS 150

G4 A01 PAPER

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G19111

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount Ave.
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 60 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ——
(c) City or town Baltimore -18.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 542 E 22nd St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Frederick

3 (b) If veteran, name war ——

3 (c) Social Security Account No. ——

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Single

6 (b) Name of husband or wife ——

6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) Aug 14, 1884

8. AGE: Years	Months	Days	If less than one day
62 63	6	24	——— hr. ——— min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER
12. Name Louis A. Fredericks
13. Birthplace Baltimore

MOTHER
14. Maiden Name Elizabeth Arthur
15. Birthplace Baltimore

16 (a) Informant Miss Isabel Frederick
(b) Address 542 E. 22nd St.

17 (a) -B- (b) Date thereof 3-11-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cathedral
Location City

18 (a) Funeral director Wiedefeld & Son
(b) Address Greenmount & 22nd St.

19 (a) MAR 10 1947 (b) Hunting Town, Md.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7, 1947, at 1:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 7, 1947, to Mar. 7, 1947, and that I last saw her alive on Mar. 7, 1947.

Immediate cause of death	Duration
Cardiac Failure	
Due to Pulmonary infarct, infected	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence 1/7/47 at 3 P.M.
(c) Where did injury occur? 542-E. 22nd St
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Means of injury Fell to floor

23. Signature Wayne N. Jacobus, M.D.
M. D.

Address Church Home & Hosp. Date signed

Howard J. Andrews, M.D. March 7, 1947

G19112

CWK-106662

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G19112

PLEASE WRITE PLAINLY. WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3- 2-
(e) Length of stay in Baltimore (yrs., mos., or days) 72- 1- 25-

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 437 E. North Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie Mary Finglas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 13-1875

8. AGE: Years	Months	Days	If less than one day
72	1	25	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Patrick Norton
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Brady
15. Birthplace Ireland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 3-11-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Govans

18 (a) Funeral director Wiedefeld & Son
(b) Address Greenmount Ave. & 22nd St

19 (a) MAR 10 1947 (Date received by Registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION A

20. DATE OF DEATH March 8 1947, at 12:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 6-1946 to Mch. 8 1947, and that I last saw h. alive on Mch. 8 1947

Immediate cause of death	Duration
Myocardial failure	
Due to Cardiac insufficiency	
Due to Hypertensive cardio-vascular disease, & generalized arteriosclerosis	
Other Conditions Obesity. Extensive calculi in Pancreatic & common ductus.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. R. Gibbs
Address Baltimore City Hosp. Date signed 3/8/47

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 B

Registered No. G19113

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1801 Patapsco St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1801 Patapsco St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nicholas A. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Katherine A. Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1907

8. AGE: Years	Months	Days	If less than one day
39	9	21	....hr. ....min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Nicholas Smith
13. Birthplace Md.

MOTHER
14. Maiden Name Mary A. ?
15. Birthplace Md.

16 (a) Informant Family
(b) Address 1801 patapsco St.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 3/10/47 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glenburnie Md.

18 (a) Funeral director James L. McCurley
(b) Address 130 E. Fort Ave.

19 (a) MAR 10 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/6/47 19..., at 8 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/5/ 1944 to 3/6/47, and that I last saw h. 1m alive on 3/6/ 1947

Immediate cause of death: Pulmonary tuberculosis — Duration: ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ....at ....M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Oeiel M. D.
Address 1226 Hanover St Date signed 3/9/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49114

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G49114

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 816 N. Vincent St. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 816 N. Vincent St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry CROMER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	—

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace South Carolina
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Benj. Cromer
13. Birthplace S. C.

MOTHER
14. Maiden Name Farmer —
15. Birthplace S. C.

16 (a) Informant Lela Green
(b) Address 1519 Laurna St

17 (a) Burial (b) Date thereof 3/11/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location West Pat Balto.

18 (a) Funeral director Metropolitan Funeral Home Inc.
(b) Address 900 N. Mount St.

19 (a) MAR 10 1947 (b) Registrar Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7th 1947 at 5-10 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary artery disease
Infection rt leg.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 3/8/47

VS 131

G49115

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G49115

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNPADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1701 No Appleton St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write "Rural" and give town)
(d) Street No. 1701 No Appleton St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bennie Caplan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Goldie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 72 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Country, province, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name David
13. Birthplace Russia

MOTHER 14. Maiden Name Etta
15. Birthplace Russia

16 (a) Informant Morris Caplan
(b) Address 1701 No Appleton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-10-47 (month) (day) (year)

(c) Cemetery or crematory
Location Hebrew Herring Run

18 (a) Funeral director Jack Lenbs Inc
(b) Address 1639 E Balto St

19 (a) MAR 10 1947 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-9- 1947, at 3:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-4 1947 to 3-9 1947, and that I last saw h alive on 3-9 1947.

Immediate cause of death: Myocardial Insufficiency — Duration: 5 days
Due to: Arteriosclerosis
Due to:
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Silvio D. Levy M. D.
Address 2322 Eutaw Place Date signed 3-10-47

VS 150

X

G19416

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83B

Registered No. G19416

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2425 E. Federal St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2425 E. Federal St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Bringham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Julia V. Bringham

6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) March 20 - 1873

8. AGE: Years	Months	Days	If less than one day
73	11	5	hr. min.

9. Birthplace England (Town, county, and state)

10. Usual Occupation

11. Industry or business Retired

FATHER
12. Name Mr. Bringham
13. Birthplace England

MOTHER
14. Maiden Name Bethia Hives
15. Birthplace England

16 (a) Informant Julia V. Bringham
(b) Address 2425 E. Federal St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-10-47 (month) (day) (year)

(c) Cemetery or crematory Woodlawn
Location

18 (a) Funeral director Ira C. Miller Inc
(b) Address 2435 E. Chase St

19 MAR 10 1947 Huntington Williams, M.D. Registrar
(Date to be filled in by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March - 10 - 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 36 to March 7 1947, and that I last saw h. alive on March 7 1947

Immediate cause of death	Duration
Cerebral Thrombosis	4 years
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address 1513 W. Mulberry Date signed March 47

V S 150

X

G49117

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G49117

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Dept
(b) Street address 3722 Glenmore Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ?
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3722 Glenmore Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Collingsworth Sr.

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Mattie Collingsworth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 4, 1870

8. AGE: Years 76 | Months 5 | Days 4 | If less than one day hr. min.

9. Birthplace Alexander, Va
(Town, county, and state)

10. Usual Occupation Retired
11. Industry or business B. & O. R.R.

FATHER
12. Name Robert Lee Collingsworth
13. Birthplace England

MOTHER
14. Maiden Name Unknown
15. Birthplace Va.

16 (a) Informant Robert Lee Collingsworth
(b) Address 3722 Glenmore. ave

17 (a) Burial (b) Date thereof Mar. 16 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore

18 (a) Funeral director Frederick A. Cole
(b) Address 1210 Longboard St.

19 (a) MAR 10 1947 (b)
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/8 1947, at 12 30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Pulaski M.D.
Medical Examiner.
Date signed 3/9/47

G49118

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G49118

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1428 McCulloh St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1428 McCulloh St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Anderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mable F.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 28, 1893

8. AGE: Years 54 | Months 1 | Days 11 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Truck driver

11. Industry or business

FATHER
12. Name James Anderson
13. Birthplace Bedford, Va

MOTHER
14. Maiden Name Indey Drakeford
15. Birthplace Atlanta, Ga

16 (a) Informant Mrs. Mable F. Anderson
(b) Address 1428 Mc Culloh St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/12/1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Chas. Sam. H. Hall & Son
(b) Address 1637 Druid Hill Ave

19 MAR 10 1947 (Date rec'd by registrar) by Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/8 1947, at 5-42 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Myocarditis
Degenerative

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 3/9/47

VS 191

G19419

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G19119

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1722 McCulloh St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1722 McCulloh St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mingow V. Wheatley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Clarence E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3, 1902

8. AGE: Years 44 | Months 8 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Martin L. Cook
13. Birthplace Caroline Co. Md.

MOTHER
14. Maiden Name Marie Harris
15. Birthplace Crisfield, Md.

16 (a) Informant Mrs. Lydia Keene
(b) Address 1722 McCulloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 10, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Baltimore, Md.

18 (a) Funeral director George H. Holland
(b) Address 1691 Druid Hill Ave

19 (a) MAR 10 1947 (Date rec'd by registrar) (b) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-6-47 19 4:40 P.M. at

21. I certify that death occurred on the date above stated; that I attended deceased from 2/12/47 to 3/6/47 19; and that I last saw her alive on 3/4/47

Immediate cause of death Pneumonia

Due to Pneumonia

Due to "

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

Duration: 4 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M.L. Barksdale

Address 776 N. Carey St. Date signed 3/6/47

VS 150

G49120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G49120 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Ballcom Sts
(c) Hospital or institution Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dor
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1327 Hollins St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Patrick J. Meade

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary F.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 3rd 1903

8. AGE: Years 43 | Months 11 | Days 6 | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Brass Finisher

11. Industry or business F. Shipyards

FATHER
12. Name Timothy Meade
13. Birthplace Ireland

MOTHER
14. Maiden Name Ann Brennan
15. Birthplace Ireland

16 (a) Informant Mary F. Meade
(b) Address 1327 Hollins St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/12/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 4700 Old Frederick Road

18 (a) Funeral director Wm. J. Cowan & Son
(b) Address 901-03 Gilmor St.

19 (a) MAR 10 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1947, at 2:01 M

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertension Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Helfrich M.D. Medical Examiner
Date signed March 9th 47

G19121 #29149

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

× 54a ✓

Registered No. G19121

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County.....
(c) City or town Petersburg — (If outside city or town limits, write RURAL and give town)
(d) Street No. 2018 Dunrey Rd. (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Wm. C. Allen - Jr.

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	—

6 (b) Name of husband or wife —
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 11-19-38

8. AGE: Years	Months	Days	If less than one day
8	3	20	.....hr. .....min.

9. Birthplace Virginia — (Town, county, and state)
10. Usual Occupation student
11. Industry or business

FATHER
12. Name Wm. C. Allen —
13. Birthplace Va. —

MOTHER
14. Maiden Name Effie Stewart
15. Birthplace Va. —

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/10/47 (month) (day) (year)
(c) Cemetery or crematory.....
Location Petersburg, Va.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) MAR 10 1947 (Registrar's signature) Huntington, W. Va. (b) Address.....

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1947 at 5:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1 1947 to Mar. 9 1947 and that I last saw him alive on Mar 9 1947

Immediate cause of death	Duration
Hyperpyrexia	
Due to Post-operative infection Incision Wound.	
Due to C.S.F. fistula.	
Other Conditions Post-operative Bleeding ulcer.	

(Include pregnancy within 3 months of death)

Date of operation 1) Jan 8, 1947 2) Feb 21, 1947
Major findings of operation: 1) Glioma 2) Perforated peptic ulcer
of autopsy: Perforated peptic ulcer 2) Glioma of Left Occipital Lobe

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature Charles W. Brueckner M. D.
Address Johns Hopkins Hospital Date signed 3-9-47

×

G19122

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

G19122 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 617 Denison St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

16

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 617 Denison St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FREDERICK SCHAEFER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Catherine Schaefer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1881

8. AGE: Years	Months	Days	If less than one day
65	8	22	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business City Employee

FATHER
12. Name Henry Schaefer
13. Birthplace Germany

MOTHER
14. Maiden Name Johanna Grecht
15. Birthplace Germany

16 (a) Informant Mrs. Catherine Schaefer
(b) Address 617 Denison St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/11/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) MAR 10 1947 (Date rec'd by registrar) (b) Huntington, Maryland Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1944 to 3/7 1947, and that I last saw h[illegible] alive on 3/7 1947.

Immediate cause of death	Duration
Intestinal Obstruction	2/28/47
Due to Carcinoma Of The Sigmoid Colon	1 Year
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 3/4/47
Major findings of operation: Carcinoma
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature J. E. Roach
Address 3629 Edmondson Ave. Date signed 3/10/47 M. D.

C19123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C19123

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edwood & Greene Sts.
(c) Hospital or institution: Univ. of Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Pasadena
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eva Stewart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Otis Stewart

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 20 1901

8. AGE: Years	Months	Days	If less than one day
45	11	17	hr. min.

9. Birthplace Anne Arundel Cnty Md (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Henson Richards
13. Birthplace Anne Arundel Cnty Md

MOTHER
14. Maiden Name Serena Baker
15. Birthplace Anne Arundel Cnty Md

16 (a) Informant Otis Stewart
(b) Address Pasdena Anne Arundel Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 12 1947 (month) (day) (year)
(c) Cemetery or crematory Magathy Cemetery
Location Anne Arundel Cnty Md

18 (a) Funeral director Joseph A. Lively
(b) Address 644 W Baltimore street

MAR 10 1947 (Date rec'd by Registrar) (b) Lively for Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/7 1947 at 1:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-7-1947 to 1 19 , and that I last saw h alive on Five hours.

Immediate cause of death	Duration
Cerebro-vascular accident	
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph L Price M. D.

Address Annex Hosp. Date signed 3-7-47

G49121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G49121

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2935 E Monument St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits write RURAL and give location)
(d) Street No. 2935 E Monument St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Novak

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna Novak

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23 / 76

8. AGE: Years 70 | Months 7 | Days 17 | If less than one day hr. min.

9. Birthplace Bohemia (Town, county, and state)

10. Usual Occupation Coal Carrier

11. Industry or business

FATHER
12. Name John Novak
13. Birthplace Bohemia

MOTHER
14. Maiden Name Anna Kadon
15. Birthplace Bohemia

16 (a) Informant Anna Novak
(b) Address 2935 E Monument

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-13-47 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Isaac Bradshaw
(b) Address 900 N. Chester St

MAR 10 1947 (Date rec'd by Registrar) (b) Huntington Williamsville

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1947, at 9 45 M

21. I certify that I took charge of the remains described above, held an Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Helfrich M.D. (Medical Examiner.)
Date signed March 9, 1947

VS 151

G49125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

137a

G49125 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) 74yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2226 E. Monument St. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Frank J. Supik.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12/30/1860

8. AGE: Years 86 Months 2 Days 8 If less than one day 8 hr. 3 min.

9. Birthplace Czecho-Slovakia (Town, county, and state)

10. Usual Occupation Master Baiter

11. Industry or business Meat Packing Dept

FATHER 12. Name Jacob Supik

13. Birthplace Europe

MOTHER 14. Maiden Name Mary Warnac

15. Birthplace Europe

16 (a) Informant Sol. L. Supik

(b) Address 732 N. Patterson Park Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 3-11-47 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Baltimore Md

18 (a) Funeral director Joseph Cracchiolo Son

(b) Address 900 S. Chester

19 (a) (Date rec'd by registrar) MAR 10 1947 (b) Livingston Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-8 1947 at 8:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-17 1947 to 3-8 1947 and that I last saw h[illegible] alive on 3-8 1947

Immediate cause of death: Coronary Thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 2-25-47

Major findings of operation: Tuberculous Urethral Prostatectomy

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lawrence J. Kurtz M.D.

Address Mercy Hospital Date signed 3-8-47

VS 150

G19126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G19126

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 16 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 319 Wyman Park Dr. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Winfred Jennings

3 (b) If veteran, name war No | 3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife John T. Jennings
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 8 - 1857

8. AGE: Years 89 | Months 3 | Days 29 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Martin Tokey
13. Birthplace Ireland

MOTHER 14. Maiden Name Mary Hennessy
15. Birthplace Ireland

16 (a) Informant JAMES J. MAGEE
(b) Address 319 Wyman Pk. Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof MAR 10-47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Chas. P. Evans & Son
(b) Address 118 W. Mt. Royal Av.

19 (a) Date rec'd (by registrar) MAR 10 1947 (b) Huntington Hollins M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-7 1947 11:45 A.M. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-20 1947 to 3-7 1947, and that I last saw h[illegible] alive on 3-7 1947.

Immediate cause of death Respiratory failure — Duration

Due to Uremia

Bilateral Senile Chronic Pyelitis Kidneys.

Other Conditions Amputated Stump Rt. Femur, Neck

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 2-19-47 at [illegible] A.M. P.M.
(c) Where did injury occur? 319 Wyman Park (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Slipped & fell in Home

23. Signature Leo Wilson, M.D., University Hosp. M.D.
Address Per: Howard J. Mellon Date signed 3/10/47
Chief Medical Examiner

VS 150

G49427

511156

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G49427 Registered No.

PRINT CLEARLY IN INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5"
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 210 N. Lorraine St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katie Dial

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Black

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-2-54

8. AGE: Years 62 | Months 4 | Days | If less than one day hr. min.

9. Birthplace S.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Dial
13. Birthplace S.C.

MOTHER
14. Maiden Name Elizabeth Kirby
15. Birthplace S.C.

16 (a) Informant Friends
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 10, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Park
Location Brooklyn, Md.

18 (a) Funeral director Elroy D. Wilson
(b) Address 1022 W. Baltimore ave

19 (a) MAR 10 1947 (Date received by registrar) (b) Huntington, Md.

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH March 7 1947, at 4.20 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 5 1947, to March 7 1947, and that I last saw her alive on March 7 1947.

Immediate cause of death Dissecting aneurysm aorta — Duration

Due to

Due to

Other Conditions Polycystic Kidneys

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Small cell carcinoma sigmoid

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. R. Mrak M. D.

Address Johns Hopkins Hosp Date signed 3-7-47

30 D

G49128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 146c

G49128 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dod
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 226 N. Montford Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sophie Scott WILLIS G 72530

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race C.

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Arthur Scott

6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) 9/16/1913

8. AGE: Years 33 Months 5 Days 22 If less than one day ____hr. ____min.

9. Birthplace Baltimore Co. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Scott
13. Birthplace Centreville Md.

MOTHER
14. Maiden Name Mable Sheppard
15. Birthplace Centreville Md.

16 (a) Informant Mable Scott
(b) Address 219 N. Montford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/12/47 (month) (day) (year)

(c) Cemetery or crematory Mt Zion
Location Elroy Allison

18 (a) Funeral director
(b) Address 1000 Brantly Ave

19 (a) MAR 8 1947 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-8- 1947, at 4 30 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hemorrhage of childbirth
(during third stage of labor)
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 3/8/47

G49129

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G49129 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5316 Cordelia Ave.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5316 Cordelia Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Ellen Zile

3 (b) If veteran, name war	3 (c) Social Security Account No.
----	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband ~~or wife~~ Charles O. Zile
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 9, 1874

8. AGE: Years	Months	Days	If less than one day
72	5	0	hr. min.

9. Birthplace Hancock, Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Thomas M. Bivens
13. Birthplace Md.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. John R. Hiltz
(b) Address 5316 Cordelia Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 12, 1947 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director D. Howard Strong
(b) Address 3207 W. North Ave.

19 (a) 10 1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9, 1947 at 5.40 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 2 1947, to March 9 1947, and that I last saw her alive on March 9, 1947

Immediate cause of death	Duration
Arteriosclerotic Heart Disease with Acute Myocarditis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alfred Cole M. D.
Address 1934 Wilkens Ave Date signed 3-10-47

VS 130

G49130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G49130 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Hyde Park - Govs (If outside city or town limits, write RURAL and give town)
(d) Street No. Rt. 16 Box 370 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel Steever

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Helen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1848

8. AGE: Years 49 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name Daniel Steever
13. Birthplace Balto Md

MOTHER
14. Maiden Name Mary Steer
15. Birthplace Md

16 (a) Informant Helen Steever
(b) Address Hyde Park Md

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 3-11-47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Balto Co

18 (a) Funeral director James J. Bruzdzynski
(b) Address 467 Eastern Ave Rd.

19 (a) (Date rec'd by registrar) (b) Signature of Registrar Thomas Williams, M.D.

MAR 10 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-7- 1947 at 8 40 a. M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Life death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mendes M.D.
Medical Examiner.
Date signed 3-7-47

X

G49131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

G49131 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 633 archer st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 633 Archer St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Noble Patton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race C | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Rosa Patton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1 1898

8. AGE: Years 49 | Months - | Days 5 | If less than one day hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation Laborer Uniform Factory

11. Industry or business

FATHER
12. Name Wonde Patton
13. Birthplace N. Carolina

MOTHER
14. Maiden Name Unknown
15. Birthplace N. Carolina

16 (a) Informant Rosa Patton
(b) Address 633 Archer St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 3-10-47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cemtey
Location Balto. Md.

18 (a) Funeral director Walter R. Foster
(b) Address 139 W. Hamburg St.

MAR 10 1947

(Date received by Registrar) (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/5 1947 to 3/6 1947 and that I last saw h alive on 3/6 1947

Immediate cause of death Pulmonary Edema — Duration
Due to Chronic Endocarditis
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Williams M. D.
Address 641 W. Lanvale St Date signed 3/10/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49132

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G49132 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4807 Reisterstown Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4807 Reisterstown Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If so, name country

3 (a) FULL NAME Annie Lukin

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Samuel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years	Months	Days	If less than one day
52			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Moses Fiskel
13. Birthplace Russia

MOTHER 14. Maiden Name Lendgrover
15. Birthplace Russia

16 (a) Informant Samuel Rubin
(b) Address 4807 Reisterstown Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-10-47 (month) (day) (year)
(c) Cemetery or crematory
Location Rehoboth Mt. Carmel

18 (a) Funeral director Jack Lewis Inc
(b) Address 1409 E Baltimore St

19 (a) Huntington Williams (Date received by registrar) MAR 10 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-9- 1947, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to March 9 1947
and that I last saw her alive on March 9 1947

Immediate cause of death	Duration
BRONCHO-PNEUMONIA	2 DAYS
Due to RHEUMATOID ARTHRITIS, SENILE CHRONIC	15 YEARS
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Manuel Levin
Address 4810 Reisterstown Rd Date signed 3/10/47

G49133

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G49133 Registered No.

Every item of information should be carefully supplied. The write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Daa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1035 W. Mulberry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William E. Cheatham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mary A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 27, 1890

8. AGE: Years 56 | Months 10 | Days 9 | If less than one day hr. min.

9. Birthplace Norfolk, Virginia (Town, county, and state)

10. Usual Occupation Cement Finisher

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name Lucy
15. Birthplace N. C.

16 (a) Informant Mary E. Cheatham
(b) Address 1035 W. Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-10-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date received by registrar) (b) Harrington Williams, Registrar

MAR 10 1947

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1947 at 8:45 A.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Reticulo Endotheliosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D. Medical Examiner
Date signed 3-6-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G-12856

G49134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G49134

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) "

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2910 Montebello Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ann Marie Abel

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race White

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6 Mar 47

8. AGE: Years | Months | Days 32 | If less than one day hr. min.

9. Birthplace University Hospital Baltimore Md.
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Owen Richard Abel
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Anna Marie Kern
15. Birthplace Baltimore Md.

16 (a) Informant Mother
(b) Address 2910 Montebello Terrace

17 (a) Burial (b) Date thereof March 10, 47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Lakelawn
Location Eastern Ave

18 (a) Funeral director George Buck
(b) Address 2400 Hartford Rd

19 MAR 10 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 Mar 1947, at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6 Mar 1947, to 8 Mar 1947, and that I last saw her alive on 8 Mar 1947

Immediate cause of death Pulmonary Atelectasis — Duration

Due to — Duration

Due to — Duration

Other Conditions Prematurity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. F. Smith M.D.

Address University Hospital Date signed 3/8/47
M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G49135

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G49135

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1316 E. Monument St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Oscar Butler

3 (b) If veteran, name war: I War

3 (c) Social Security Account No. 218-01-7964

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7 1894

8. AGE: Years	Months	Days	If less than one day
52	9	1	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Music

11. Industry or business

FATHER
12. Name Joseph Butler
13. Birthplace Dorchester Co Md

MOTHER
14. Maiden Name Sarah Wilson
15. Birthplace Centreville Md

16 (a) Informant Edna Butler
(b) Address 1316 E Monument St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 13 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location A A Co Md

18 (a) Funeral director Robert E. Williams
(b) Address 1515 McElderry St

19 (a) Date received for registration MAR 10 1947 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/8 1947, at 11:20 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. J. Sobieski M.D. Medical Examiner.
Date signed 3/9/47

G49136

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G49136

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2012 Maryland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2012 Maryland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace D Comtois

3 (b) If veteran, name war	3 (c) Social Security Account No.
— W	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Francis N
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug 3 1868
8. AGE: Years 78 | Months 6 | Days 9 | If less than one day ... hr. ... min.
9. Birthplace Scotland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wilhem Woluscroft
13. Birthplace England

MOTHER
14. Maiden Name Mary A Price
15. Birthplace England

16 (a) Informant Francis Comtois
(b) Address 2012 Maryland Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/12/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md
18 (a) Funeral director Wilhem Bollman
(b) Address 1217 N Fulton Ave
19 (a) MAR 10 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1947, at 4:20 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1 1947 to 19 ... and that I last saw h alive on Mar 8 1947

Immediate cause of death	Duration
Carcinoma	2
Pneumonia	1
Due to	
Due to	
Other Conditions Arterio S	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. H. Pearce M. D.
Address 2405 E. Chase Date signed Mar 10 47

VS 150

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C19137

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 24 Benkert (Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 24 Benkert (Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Henry Addison

3 (b) If veteran, name war	3 (c) Social Security Account No.
N	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24, 1892

8. AGE: Years	Months	Days	If less than one day
54	7	14	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Asst. Treas.
11. Industry or business Insurance Adjustor

FATHER
12. Name William Sherman Addison
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Harriet Alexander
15. Birthplace Baltimore Md

16 (a) Informant Mrs Mary Addison
(b) Address 24 Benkert Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/11/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Md

18 (a) Funeral director Jackson & Hare
(b) Address 1217 Eutaw St

19 (a) MAR 10 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to Mar 8 1947, and that I last saw h alive on Mar 8 1947.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Arteriosclerosis	
Due to	
Other Conditions Cardiac Decompensation	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [illegible]
Address 410 Medical Arts Bldg Date signed 3/10/47

VS 150

G49438

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Register G49438

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1013 Wilmot Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 17 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1013 Wilmot Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjiman F. Wells

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Minnie May Wells

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2, 1868

8. AGE: Years 78 | Months 9 | Days 7 | If less than one day hr. min.

9. Birthplace Utica, Missouri (Town, county, and state)

10. Usual Occupation Restaurant

11. Industry or business

FATHER
12. Name Agar Wells
13. Birthplace Utica, Missouri

MOTHER
14. Maiden Name Margaret A. Hart
15. Birthplace Utica, Missouri

16 (a) Informant William F. Wells
(b) Address 1013 Wilmot Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/12/47 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill
Location Anne Arundel Co Md

18 (a) Funeral director Wm. Cook Inc.
(b) Address 1247 St. Paul St.

19 MAR 10 1947 (Date rec'd by registrar) (b) Huntington Willi... Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1947, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1946 19 to March 9 1947 and that I last saw h[illegible] alive on March 6th 1947.

Immediate cause of death Cerebral Hemorrhage.

Due to Hypertension.

Due to

Other Conditions Hypertension and Heart.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

	Duration
Cerebral Hemorrhage.	
Due to Hypertension.	2 years
Due to	
Other Conditions Hypertension and Heart.	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Trumpp M. D.
Address 623 E. N. Avenue Date signed 3-9-47

83a

G19139

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 195c

Registered No. G49139

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 622 Pennsylvania Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 622 Pennsylvania Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sallie Eudora Spur

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife John A Spur
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 28 1876

8. AGE: Years	Months	Days	If less than one day
70	4	11/2	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Richard Murdock
13. Birthplace Md

MOTHER
14. Maiden Name Sarah Cosden
15. Birthplace Md

16 (a) Informant Gladys L Story
(b) Address 622 Pennsylvania Ave
17 (a) Burial (b) Date thereof 3/13/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodland Park
Location Baltimore Md
18 (a) Funeral director Wilson & Ford
(b) Address 1217 E Fayette St
19 (a) (Date rec'd by registrar) MAR 10 1947 (b) Hunting for Williams Md

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 29 1941 to Mar. 9 1947 and that I last saw h-w alive on Mar. 7 1947

Immediate cause of death	Duration
Cardiac decompensation	3 yrs
Due to Arteriosclerosis & Hypertension - history	20 yrs
Due to	
Other Conditions Acute attacks of Bronchitis (Include pregnancy within 3 months of death)	2 yrs.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature David Risner
Address 1125 Maryland Ave Date signed 3/10/47

VS 150

G49140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G49140

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 83 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 522 E 20 St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Moan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/8/63

8. AGE: Years 83 | Months 6 | Days 11 12 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name John Moan
13. Birthplace Ireland

MOTHER 14. Maiden Name Mary Kelly
15. Birthplace Ireland

16 (a) Informant Alice C Moan
(b) Address 522 E. 20th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/12/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Wm Cook Inc
(b) Address 217 S. Paca St

19 MAR 10 1947 (To be filled in by registrar) (b) Funeral Director for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/9/47 at 4:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/8/47 to 3/9/47 and that I last saw him alive on 3/9/47

Immediate cause of death: Cardiac Failure — Duration

Due to: Hypertensive Debilitation

Due to:

Other Conditions: Duod. Ulcer

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide? Accident
(b) Date of occurrence 3/8/47 at 11:00 A.M.
(c) Where did injury occur? Balto (City or town) Md. (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No (Specify type of place)
(e) Means of injury: Slipping & fall to floor

23. Signature [illegible] M. D.
Address [illegible] Date signed 3/9/47

VS 150

Injury occurred at Little Italy Park. Homicide suicide? X

G49141

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G19141

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1024 E 20th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2806 Kennedy Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary A Snyder

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John A

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 31, 1880

8. AGE: Years 66 | Months 6 | Days 9 10 | If less than one day hr. min.

9. Birthplace Ga (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name (Johnson) Blair
13. Birthplace Johnson

MOTHER
14. Maiden Name Louise (Johnson)
15. Birthplace Johnson

16 (a) Informant Daniel A Snyder
(b) Address 3207 Ruxby St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/12/47 (month) (day) (year)
(c) Cemetery or crematory Woodland Park
Location Baltimore Md

18 (a) Funeral director Wilson & Sons
(b) Address 1214 E Fort Ave

19 (a) MAR 10 1947 (Date rec'd by registrar) (b) Hurried for Wilson M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1947, at 1:14 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 26 1947 to March 9 1947. and that I last saw h alive on 3-8- 1947.

Immediate cause of death: Coronary Occlusion — Duration: Few minutes

Due to Generalized arterio-sclerosis — 3-4 yrs.

Due to

Other Conditions Chronic Nephritis — 2 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert Herman M. D.
Address 2424 Eutaw Place Date signed 3-10-47

94a

C49142

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C49142

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 105 days
(e) Length of stay in Baltimore (yrs., mos., or days) 105 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Florida (b) County
(c) City or town Mayport (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Williams, Alton Oferal

3 (b) If veteran, name war WWI

3 (c) Social Security Account No. ?

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Blanche Williams

6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) May 4, 1893

8. AGE: Years 53 | Months 10 8 | Days 4 | If less than one day hr. min.

9. Birthplace Reedville, Va. (Town, county, and state)

10. Usual Occupation Master

11. Industry or business Seafarer

FATHER
12. Name James B. Williams
13. Birthplace North Dublin Co. Va.

MOTHER
14. Maiden Name Tebidore Edwards
15. Birthplace North Dublin Co. Va.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 3/11/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Wilson & Son
(b) Address 1317 E. Fort Ave.

19 MAR 10 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1947, at 11:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 13 1946, to Mar. 8 1947, and that I last saw him alive on Mar. 8 1947.

Immediate cause of death Adenocarcinoma of rectum with metastasis to liver — Duration UNKNOWN

Due to

Due to

Other Conditions Pneumonia, bronchial — Duration ABOUT 2 wks.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M.D.
Address Clinical Director Date signed 3/10/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

G49143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G49143

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1519 S. Charles St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Life
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1519 S. Charles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward M. Foster

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Annie K. Foster (nee Handschuh) (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) OCT. 21, 1884

8. AGE: Years 62 | Months 4 | Days 18 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Glass Furnace Attendant

11. Industry or business Cars - Lowery Glass Co.

FATHER
12. Name Henry Foster -
13. Birthplace Germany

MOTHER
14. Maiden Name Married - (?)
15. Birthplace Ireland

16 (a) Informant Mrs. Annie K. Foster (Wife)
(b) Address 1519 S. Charles St Balto Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 12 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director A. Bowling Evans
(b) Address 1008 S. Charles St, Balto, Md.

MAR 10 1947 (Date rec'd by registrar) (b) Registrar Lexington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9, 1947 at 4:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/18/1926 to Mar. 9 1947 and that I last saw him alive on 3/8/1947.

Immediate cause of death: Coronary arteriosclerosis. — Duration: 10 mos.

Due to —

Due to —

Other Conditions General arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

D. Signature Harry Lacell M. D.

Address 1126 Hanover St Date signed 3/10/47

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49144

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G49144

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 40 S. High Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 40 S. High Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LUCAS ZANKOWITZ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Viola L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): October 26 189[illegible]

8. AGE: Years 55 | Months 56 | Days 4 | If less than one day hr. min. 11

9. Birthplace: Poland
(Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER
12. Name: Frank Zankowitz
13. Birthplace: Poland

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Poland

16 (a) Informant: Viola Zankowitz
(b) Address: 40 S. High St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 11 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Randall-Disque
(b) Address 40 S. High St.

19 (a) MAR 10 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6, 1947, at 5:10 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: ~~natural causes~~ ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Hypertensive cardiovascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. G. Helfrich, M.D.
per [illegible] M.D.
Medical Examiner.
Date signed

G19445 Hook

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G19445

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 32d st + Cohen t
(c) Hospital or institution Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 dys.
(e) Length of stay in Baltimore (yrs., mos., or days) 47 - 8 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No 502 Evesham Ave Balto 10
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs ETHEL William Henry Hook

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	

6 (b) Name of husband or wife William Henry Hook
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) [illegible] 1878

8. AGE: Years 48 (68) | Months 05 (08) | Days 29 (21) 2 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name George L. Goodman
13. Birthplace Maryland

MOTHER
14. Maiden Name Adelaide ?
15. Birthplace Virginia

16 (a) Informant husband.
(b) Address same.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/11/47 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location Govans Md.

18 (a) Funeral director John A. McKean
(b) Address 4211 Greenmount Ave

19 (a) MAR 10 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-8 1947, at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-4 1947, to 3-8 1947, and that I last saw h.e.r. alive on 3-5 1947.

Immediate cause of death Malignant ovary
Carcinoma

	Duration
Due to Metastasis to - cranial pressure	
Due to Sept Decub & hematoma	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 2-27-47
Major findings of operation: Sept decub hematoma
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert J Mace M. D.
Address Union Memorial Date signed 3-9-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

G49146

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G49146 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 S Payson St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V°
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 212 S. Payson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas F. Weatherall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced widowed

6 (b) Name of husband or wife Lottie Alice J. Hagee

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 11, 1860

8. AGE: Years 87 | Months | Days 26 | If less than one day ... hr. ... min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Retired Boiler Maker Helper

11. Industry or business B. & O. R. R.

FATHER 12. Name Thomas Weatherall

FATHER 13. Birthplace Ireland

MOTHER 14. Maiden Name Unknown

MOTHER 15. Birthplace Ireland

16 (a) Informant Miss Beatrice M. Weatherall

(b) Address 212 S. Payson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/11/47 (month) (day) (year)

(c) Cemetery or crematory St. Peters

Location 1300 Maryland Ave

18 (a) Funeral director Harry A. Kirkpatrick

(b) Address 410 Edmondson Ave

MAR 10 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/7/47 19..., at ... M

21. I certify that death occurred on the date above stated, that I attended deceased from 1/4 19 47 to 3/7 19 47 and that I last saw him alive on 3/7 19 47

Immediate cause of death Myocarditis — Duration 1yo

Due to Hypostatic pneumonia

Due to Senility Arterial Sclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. D. Cohn M.D.

Address 2145 W Balto Date signed 3/8/47

X

G49147 — BALTIMORE CITY HEALTH DEPARTMENT — G49147

CERTIFICATE OF DEATH

178a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1704 W. 33rd St D.O.A.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 31 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 291 E. 31st Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Francis Leroy (Frank) Henbeck

3 (b) If veteran, name war: W.W. Marine Corps
3 (c) Social Security Account No. 212-16-9460

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Charlotte V. Henbeck
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 6-1915
8. AGE: Years 31 Months 8 Days 2 If less than one day hr. min.
9. Birthplace Washington, D. C. (Town, county, and state)
10. Usual Occupation Branch Manager
11. Industry or business Butler Bros. (Furniture)
12. FATHER Name George F. Henbeck
13. Birthplace Maryland
14. MOTHER Maiden Name Mary C. Hammond
15. Birthplace Maryland
16 (a) Informant Mrs. Charlotte V. Henbeck
(b) Address 291 E. 31st Street
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 11-1947 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland
18 (a) Funeral director Burgee Funeral Home
(b) Address 3421 Falls Road
19 (a) MAR 10 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/8 1947, at 7:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Asphyxia due to
Inhalating gas
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/8/47 at about 7:00 P.M. 13/8
(b) Where did injury occur? 1704 W. 33rd St
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury Gas admitting from stove burners

23. Signature [signature] M.D. Medical Examiner.
Date signed 3/9/47

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49148

420538

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

148a

G49148 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 711 Bradley, St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME EMMA Gittings

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	black	married

6 (b) Name of husband or wife Louis Gittings
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 4-28-12

8. AGE: Years	Months	Days	If less than one day
34	10	10	.....hr. .....min.

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Willie Chandler
13. Birthplace Va.

MOTHER
14. Maiden Name Annie Battle
15. Birthplace N. C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 3-12-47
(Burial, cremation, or removal) (mouth) (day) (year)
(c) Cemetery or crematory St. James
Location Hayre de Grace, Md.
18 (a) Funeral director Elmer E. Ballard
(b) Address Havre de Grace, Md.
19 MAR 10 194 (b) Huntingtown, Md.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1947, at 10 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-24- 1947 to 3-8- 1947 and that I last saw her alive on 3-8- 1947

	Duration
Immediate cause of death Pulmonary Embolism	15-24 hrs.
Due to Hydronephrosis	1-2 mo.
Due to X-ray therapy	5 mo.
Other Conditions Carcinoma of cervix	6+ mo.

(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
of autopsy: Gen. abdom.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature W. Thom Lund M. D.
Address Johns Hopkins Date signed 3/10/47

X

G49419

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓95c

Registered No. G49419

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2607 Ailsa Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2607 Ailsa Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME E. Milton Wells

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Mary W. Wells
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 20, 1872

8. AGE: Years	Months	Days	If less than one day
74	10	16	hr. min.

9. Birthplace Port Tobacco, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Salesman

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Christine Wells
(b) Address 2607 Ailsa Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/11/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 MAR 10 1947 Huntington Williams, M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION 40

20. DATE OF DEATH March 8th, 1947, at 11 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1945 to Mar. 1947 and that I last saw him alive on Mar 7 1947

Immediate cause of death	Acute pulmonary edema.	Duration
Due to	Congestive heart failure	
Due to	Coronary Thrombosis causing infarction	
Other Conditions		

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas J. Brennan M. D.
Address 5217 Harford Rd Date signed 3-10-47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49450

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 13/a

Registered No. G49150

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 454 Furrow St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 454 Furrow St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN A. HOFMANN, SR.

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Margaret M. Hofmann nee Kreimer 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 24, 1860

8. AGE: Years	Months	Days	If less than one day
86	3	14	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Adam Hofmann
13. Birthplace Germany

MOTHER
14. Maiden Name Rose ?
15. Birthplace Germany

16 (a) Informant Mrs. Rosa C. Gerlach, daughter
(b) Address 2741 Maryland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/11/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Balto, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 10 1941 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8, 1947, at 8.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/26 1946 to 3/8 1947, and that I last saw him alive on 3/7 1947.

Immediate cause of death	Duration
Cardiac failure - 3 mo.	
Due to Arturio scleratic cardios-vascular- reual disease	2 or 3 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George A. Kempp M. D.
Address 3030 Edmondson Ave. Date signed 3/10/47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G49151

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2924 Guilford Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2924 Guilford Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES JOSEPH MOTT

3 (b) If veteran, name war: none
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife: Mary K. Mott
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31, 1872

8. AGE: Years	Months	Days	If less than one day
74	7	8 ?	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Shipping Clerk
11. Industry or business

FATHER
12. Name George P. Mott
13. Birthplace Long Island, N. Y.

MOTHER
14. Maiden Name Elizabeth Carman
15. Birthplace Long Island, N. Y.

16 (a) Informant Mrs. Mary K. Mott
(b) Address 2924 Guilford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/12/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 10 1947 (Date rec'd by registrar) (b) [illegible] Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9, 1947, at 3:00 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 8, 1946 to Mar 9, 1947 and that I last saw him alive on Dec. 8, 1947

Immediate cause of death	Duration
Myocardial degeneration, heart failure	3 mo
Due to Coronary thrombosis	3 mo
Due to	
Other Conditions Mild arterio-sclerosis, Senile deafness	7

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice E. Shaner M. D.
Address 3 Doncaster Rd Date signed 3/10/47

93D

G49452

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G49452 Registered No. 61

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd St. & Guilford Ave.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1202 Waldon Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edith L. Brown

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Luther O. Brown
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Oct. 23, 1889

8. AGE: Years	Months	Days	If less than one day
57	4	15/16	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name Lloyd Mason.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Mary Snyder.
15. Birthplace ?

16 (a) Informant Hospital Records.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-11-47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Healey P. McNamara
(b) Address 4414 Park Road.

MAR 10 1947 (Date received) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8, 1947, at 2 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-8-47 19— to 3-8- 1947 and that I last saw h— alive on 3-8- 19 47

Immediate cause of death	Duration
Cerebral Hemorrhage.	1 day
Due to Hypertensive Cardiovascular disease.	>
Due to	
Other Conditions Diabetes mellitus	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature George H. Schlemmer, Jr. M.D.
Address 11 W. Mt. Date signed 3/9/47

VS 150

93D

Forwarded to C Chase St

C49153

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. C49153

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 109 W. 29th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 109 W. 29th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Percy Wm. Bloom

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M.

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Jane R.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 9, 1875

8. AGE: Years 71 | Months 5 | Days 29 | If less than one day hr. min.

9. Birthplace Penna (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER 12. Name Abraham A. Bloom

13. Birthplace Pa

MOTHER 14. Maiden Name Margaret Peoples

15. Birthplace Pa

16 (a) Informant Charles A. Bloom

(b) Address 907 Rosedale st.

17 (a) burial (b) Date thereof Mar. 12 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Meadow Ridge

Location Parkville Md

18 (a) Funeral director Williams Cook Inc

(b) Address 1217 St. Paul st.

19 (a) MAR 10 1947 (Date rec'd by registrar) (b) Washington for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1947 at 4:39 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 8 1947 to March 9 1947 and that I last saw him alive on March 8 1947.

	Duration
Immediate cause of death: Acute Congestive Heart Failure	1 DAY
Due to: Arteriosclerotic Heart Disease	?
Due to: Generalized Arteriosclerosis	
Other Conditions: Ascites, hepatomegaly	
dependent edema. (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Theodore E. Woodward M. D.

Address 11 E. Chase St. Balto. 2, Md. Date signed 3/9/47

VS 153

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

649154

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5 1 B

Registered No. 649454

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2693 Wilkens Ave.
(c) Hospital or institution: V°
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2693 Wilkens Ave.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Christopher M. Kinkeer

3 (b) If veteran, name war None

3 (c) Social Security Account No. 212-14-9328 M

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Clara A. Kinkeer

6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Dec. 19, 1868

8. AGE: Years 78 | Months 2 | Days 1922 | If less than one day hr. min.

9. Birthplace Richmond, Virginia
(Town, county, and state)

10. Usual Occupation Foreman

11. Industry or business Retired

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Clara A. Kinkeer
(b) Address 2693 Wilkens Ave.

17 (a) Burial (b) Date thereof 3-12-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Westview
Location Baltimore, Md.

18 (a) Funeral director George L. Lehnert
(b) Address 2101 Frederick Ave.

MAR 10 1947 (b) Huntington Williams M.D.
(Date received by Registrar) (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10, 1947, at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/6/47, 19..., to 3/10, 1947. and that I last saw him alive on 3/10, 1947.

Immediate cause of death	Duration
Carcinoma of prostate	1 yr.
Due to	
Due to	
Other Conditions Carcinoma of liver	

(Include pregnancy within 3 months of death)

Date of operation March 4, 1947

Major findings of operation: Carcinoma of liver

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M. D.

Address 2030 Wilkens ave Date signed 3/10/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49155

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G49155

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5220 Wilton Heights Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5220 Wilton Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Gregory Colvel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Verna May

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) March 12 1888

8. AGE: Years 58 | Months 11 | Days 24 | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business: Advertising Business

FATHER
12. Name Robert E. Colvel
13. Birthplace Balto Md

MOTHER
14. Maiden Name Martha Donna
15. Birthplace Balto Md

16 (a) Informant Mrs Verna M. Colvel
(b) Address 5220 Wilton Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-11-47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director Lorman Byers
(b) Address 5305 Park Heights Ave

19 (a) MAR 10 1947 (Date rec'd by registrar) (b) Huntington Hill Registrar, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 8, 1947 at 2 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 31, 1947 to Mar 8 1947, and that I last saw h. alive on Mar 7 1947.

Immediate cause of death	Duration
Pulmonary Bronchial Pneumonia	
Due to	
Due to	
Other Conditions Chr. Bronchitis Arteriosclerosis (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George E. Glennon M.D.
Address 520 Medical & Sci Bld Date signed 3/10/47 M. D.

VS 150

G49156

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G49156

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Oliver & Caroline
(c) Hospital or institution: St. Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Old Frederick Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ambrose M. GAY

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Myrtle I.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7 1890

8. AGE: Years	Months	Days	If less than one day
57	0	3	hr. min.

9. Birthplace Blythe Georgia (Town, county, and state)

10. Usual Occupation Contractor

11. Industry or business Own Business

FATHER 12. Name James W. Gay

13. Birthplace Blythe Ga.

MOTHER 14. Maiden Name Lelia McGahee

15. Birthplace Ga

16 (a) Informant Mrs Myrtle I. Gay

(b) Address Old Frederick Rd & Myers Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-13-47 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cem

Location Pikesville, Md.

18 (a) Funeral director Young, Byers

(b) Address 5005 Cath. Baltimore

19 (a) MAR 10 1947 (Date rec'd by registrar) (b) Huntington, West Virginia

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/10 19/47, at 3:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/5/1947 to 3/10 1947 and that I last saw him alive on 3/10/1947

Immediate cause of death Cardiac Failure — Duration

Due to Coronal Thrombosis

Due to Hypertension Chronic Nephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward H. Young, M.D.

Address St. Joseph Hosp. Date signed 3/10/47

G49157

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G49457

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

LARGE RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2708 Elliott St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2708 Elliott St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George P Kroltmon

3 (b) If veteran, name war N
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Separated

6 (b) Name of husband or wife Elizabeth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24, 1862

8. AGE: Years	Months	Days	If less than one day
84	10	15	hr. min.

9. Birthplace Ga
(Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Anna Hoyt
(b) Address 2708 Elliott St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/9/47 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Baltimore Md

18 (a) Funeral director Wilson & Son
(b) Address 1217 Paul St

19 Date received by Local Registrar MAR 11 1947 (b) Signature of Local Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1947 at 1:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1947 to March 9 1947 and that I last saw h[illegible] alive on March 3 1947.

Immediate cause of death Coronary Thrombosis — Duration

Due to Arteriosclerosis — 3 years

Due to

Other Conditions Postapoplectic Hemiparesis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Trump M. D.
Address 1623 E. N. Ave Date signed 3-10-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19158

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G19158

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd and Calvert St.
(c) Hospital or institution: Union Memorial.
(d) Length of stay in hospital or inst. (yrs., mos., or days) less than 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1221 Valley St Balto (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MASON, BENJAMIN

3 (b) If veteran, name war

3 (c) Social Security Account No. 2/2-12-1826

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife MRS BENJAMIN MASON
6 (c) If alive, give age [redacted] years

7. Birth date of deceased (mo., day, yr.) SEPT 30 1869

8. AGE: Years	Months	Days	If less than one day
77	5	10	hr. min.

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation Mill man. Lumber business
11. Industry or business

FATHER
12. Name Benjamin Mason.
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Dove
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/13/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

MAR 11 1947 (Date received by Registrar)
(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1947, at 2:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 10, 1947 19 , and that I last saw h. alive on March 10 1947.

Immediate cause of death	Duration
Heart failure	
Due to Arteriosclerotic Heart disease	
Due to	
Other Conditions Diabetes	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph C. Presti M.D.
Address Union Mem. Hosp. Date signed March 10 1947

VS 150

93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G49159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3113 Guilford Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3113 Guilford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henrietta Johanna Appel

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-20-2489

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 18,1876

8. AGE: Years	Months	Days	If less than one day
70	4	20	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Henry Appel
13. Birthplace Hessen, Damstadt, Germany

MOTHER
14. Maiden Name Meta Freytag
15. Birthplace Bremen, Germany

16 (a) Informant Mrs. Mary Appel
(b) Address 3113 Guilford Ave.

17 (a) Burial (b) Date thereof March 11,1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Westenn Cemetery
Location Baltimore, Md.

18 (a) Funeral director Miller & Amoroso
(b) Address 4910 Liberty Heights Ave.

19 (a) (b) Huntington Woods, Md.
(Date rec'd by registrar)
MAR 11 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946 to MAR. 8 1947. and that I last saw her alive on MAR. 7 1947.

Immediate cause of death	Duration
CEREBRAL HEMORRHAGE (MASSIVE)	SUDDEN
Due to MYOCARDIAL DEGENERATION & AURICULAR FIBRILLATION	6 MOS.
Due to HYPERTENSIVE HEART DISEASE	2 YRS.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert A. Healy M. D.
Address Medical Arts Bldg Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49460

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 937

G49150 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Sts
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 37 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 50 45!

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Rural - Glenburnie
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) **FULL NAME** Reverend John G Field

3 (b) If veteran, name war No | 3 (c) Social Security Account No. None

Sex Male | Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Nellie Hall Field

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Jan. 23 1873.

8. AGE: Years 74 | Months 1 | Days 15 | If less than one day hr. min.

9. Birthplace England (Town, county, and state)

10. Usual Occupation Retired Clergyman

11. Industry or business

FATHER 12. Name John G. Field

13. Birthplace England

MOTHER 14. Maiden Name Unknown

15. Birthplace England

16 (a) Informant Mrs. Nellie Hall Field

(b) Address Glenburnie, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 13 1947 (month) (day) (year)

(c) Cemetery or crematory Asbury Park

Location Arnold Md

18 (a) Funeral director E. F. Hammerly

(b) Address 1003 W. Baltimore St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 MAR 11 1947 Registrar for Health Officer

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1947; at 5:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/3 1947 to 3/10 1947. and that I last saw him alive on 3/10 1947.

Immediate cause of death Cardiac failure

H. A. C. D. disease of 4 days | Duration 37 days

Due to

Due to

Other Conditions B.H.P.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature C. E. Gonzales

Address Maryland G. Hosp. Date signed M. 3 D. 10/47

X

G49161

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G49161 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 119 S. Calhoun St.
(c) Hospital or institution:
19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 119 S. Calhoun St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rachel A. Diffenderfer

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife James Phillip Diffenderger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10, 1865

8. AGE: Years	Months	Days	If less than one day
81	11	-	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name William Spurrier
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Frizzell
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. John W. Diffenderfer
(b) Address 119 S. Calhoun St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 12, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Baltimore, Md.

18 (a) Funeral director Miller Lamborn
(b) Address 1006 E. Baltimore Street

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MAR 11 1947

VS 158

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1947, at 9.15A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 14 1946, to Mar 10 1947, and that I last saw her alive on Mar. 10 1947.

Immediate cause of death	Duration
(a) Arteriosclerotic Cardio-Vascular Disease.	3
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Carl A. Ross King M. D.
Address 1326 W. Lombard St. Date signed 3/10/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49462

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

G49462

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3403 Milford Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3403 Milford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert E. Newcomer

3 (b) If veteran, name war None

3 (c) Social Security Account No. 220-07-2158

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Margaret T. Newcomer

6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) October 15, 1868

8. AGE: Years 78 | Months 4 | Days 24 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Sales Manager

FATHER
12. Name Christopher Newcomer
13. Birthplace Hagerstown, Md.

MOTHER
14. Maiden Name Mary Murray
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Margaret L. Newcomer
(b) Address 3403 Milford Ave.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Mar. 12, 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director [illegible]
(b) Address 4516 Liberty Heights Ave.

19 (a) MAR 12 1947 (Date rec'd by registrar) **(b)** [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1947, at 8.40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Mch 9 1946, to Mch 9 1947, and that I last saw him alive on Mch 9 1947

Immediate cause of death: Cerebral accident — Duration: 2 days
Due to: Hypertension Cardio Vasc Disease
Due to: Generalized Arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Thos J Abbott M. D.
Address 4509 Liberty Hgts Ave Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49163

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G49163 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital or institution: St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 71 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1804 E. Pratt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Schaub (GEORGE SCHAUB, SR.)

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife: Anna (Strauss) Schaub

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb. 18, 1876

8. AGE: Years	Months	Days	If less than one day
71	0	18	....hr. ....min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business

FATHER
12. Name: John Schaub
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15. Birthplace: "

16 (a) Informant: Charles Schaub - son
(b) Address: 1804 E. Pratt Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/11/47 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cemetery
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC?
(b) Address: NORTH AVE. & BROADWAY

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 11 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1947, at 10:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/4 1947 to 3/8 1947 and that I last saw h. alive on 3/8 1947

Immediate cause of death	Duration
Cardiorasp. failure	
Due to Uremia	
Due to Chronic nephritis	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel T. Wilson M. D.
Address St. Joseph's Hosp. Date signed 8 Feb 47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49164

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 307

G49164 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital. 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 804 E. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: SAMUEL COOPER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1901

8. AGE: Years	Months	Days	If less than one day
46	1	7	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Samuel Cooper
13. Birthplace Md.

MOTHER
14. Maiden Name Susie Green
15. Birthplace Md

16 (a) Informant Mrs. Ida Edge
(b) Address 915 Edmondson Ave.

17 (a) Burial (b) Date thereof 3-13-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) Filed (b) Registrar
MAR 11 1947

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9, 1947, at 9.50 a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Syphilitic aortitis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl K. Rogers M.D.
Medical Examiner.
Date signed 3-10-47

G49465

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G49465

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Road
(c) Hospital or institution: Snyder Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3243 Cecil Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET (MEINSCHEIN) KOHLHEPP

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John Kohlhepp
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 6, 1859

8. AGE: Years 87 | Months 11 | Days 2 | If less than one day hr. min.

9. Birthplace: Germany (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: John Meinschein
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Germany

16 (a) Informant: Gertrude Loeffler
(b) Address: 3243 Cecil Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/11/47 (month) (day) (year)
(c) Cemetery or crematory: St. Pauls Fifth Ref.
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) MAR 1947 (Date received by Registrar) (b) Huntington Will, Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8, 1947, at 3 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1944 to 19, and that I last saw h alive on 19.

Immediate cause of death: Acute heart failure — Duration
Due to: Arteriosclerotic Cardio-Vascular Disease
Due to:
Other Conditions: Recent fracture neck of rt. femur
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 9/8
(a) Accident, suicide, or homicide: Accidental
(b) Date of occurrence 2-15-47 at A.M.
(c) Where did injury occur? 3243 Cecil Avenue (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? no
(e) Means of injury: Woman fell to floor

23. Signature: Howard J. Mullins, M.D.
Address 3400 Erdman Ave. Date signed 3/10/47

Howard J. Mullins, M.D.

G19466

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G19466

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2341 Harford Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2341 Harford Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kate Wiseman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife John H. Wiseman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12th 1861

8. AGE: Years	Months	Days	If less than one day
85	9	28	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name John Betz
13. Birthplace Germany

MOTHER
14. Maiden Name Phillipina Spring
15. Birthplace Germany

16 (a) Informant Mr. Louis A. Wiseman
(b) Address 2341 Harford Road

17 (a) burial (Burial, cremation, or removal) (b) Date thereof March 13/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location 1112 S. Bonsal St.

18 (a) Funeral director Lasach Funeral Homes
(b) Address 7401 Belair Road

19 (a) MAR 11 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10th 1947, at 8:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 10 1947 to Mar 10 1947 and that I last saw h[illegible] alive on March 9 1947

	Duration
Immediate cause of death Bronco Pneumonia	2d
Due to Arterio Sclerosis Hypertension	2 mo
Due to Chronic Interstitial Nephritis	2 mo
	2 mo
Other Conditions Gangrene of Toes. bullous due to terminal Circulatory	

(Include pregnancy within 3 months of death)
Date of operation Nil
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T F A Stevens M. D.
Address 2818 Harford Rd Date signed 3-10-47

VS 150--

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49467

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

✓ G49467 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Temple Garden Apts.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Days.

2. USUAL RESIDENCE OF DECEASED:
(a) State New York (b) County
(c) City or town New York (If outside city or town limits, write RURAL and give town)
(d) Street No. Hotel Westover (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME HARRY ARNOLD

3 (b) If veteran, name war

3 (c) Social Security Account No. 082-16-3335

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Gussie B. Arnold
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1, 1865

8. AGE: Years	Months	Days	If less than one day
81	6	8	hr. min.

9. Birthplace New York (Town, county, and state)
10. Usual Occupation Baker's Supplies
11. Industry or business

FATHER
12. Name Irving Arnold,
13. Birthplace N. Y.

MOTHER
14. Maiden Name Charlotte Ganpert,
15. Birthplace N.Y.

16 (a) Informant Mrs. Leonard Weinberg,
(b) Address Temple Garden Apts.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 3/11/47. (month) (day) (year)
(c) Cemetery or crematory Greenmount.
Location Balto. Md.

18 (a) Funeral director Baltimore Funeral Service
(b) Address 1902 Eutaw Place.

19 (a) (Date rec'd by registrar) MAR 11 1947 (b) Burlington, Vt.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9th. 1947, at Ri

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1945 to Mar 9 1947 and that I last saw h[illegible] alive on Mar 9 1947.

	Duration
Immediate cause of death Coronary Thrombosis	5 hours
Due to Arteriosclerosis	2 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alan Bernstein M. D.
Address 1109 N. Calvert St. Date signed 3/10/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G49168

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1002 E. Lombard St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) One 3
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1002 E. Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Max Goldman

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Fannie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1876

8. AGE: Years	Months	Days	If less than one day
71			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Pesah Goldman
13. Birthplace Russia

MOTHER
14. Maiden Name
15. Birthplace Russia

16 (a) Informant Harry Goldman
(b) Address 3937 Liberman Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-11-47 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run
Location Druidcrest Lane

18 (a) Funeral director Jack Penna Inc
(b) Address 1739 E. Baltimore St

19 (a) (Date rec'd by registrar) MAR 11 1947 (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1947, at 9:10 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary artery disease

Due to Generalized arteriosclerosis.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Ryer M.D.
Medical Examiner.
Date signed

G49169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

G49169 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3107 Beverly Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3107 Beverly Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Geo. W. Wilkinson Sr.

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary E. Wilkinson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 28, 1873

8. AGE: Years	Months	Days	If less than one day
74	0	8	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name H. E. Wilkinson
13. Birthplace Unknown

MOTHER
14. Maiden Name Catherine Fleming
15. Birthplace Unknown

16 (a) Informant Geo. W. Wilkinson Jr.
(b) Address 2227 Pelham Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 11/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director Philip Hewins Sons
(b) Address 2024 Orleans St.

19 (a) (b)
(Date received by registrar) Registrar

MAR 11 1947 Huntington Hillsboro, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8/47 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 to 3-8 1947
and that I last saw h alive on 3-7 1947

Immediate cause of death Carcinoma Bladder — Duration 9 Mo.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation Sept. 1946
Major findings of operation: Carcinoma Bladder
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. W. Peake M. D.
Address 4508 Harford Rd Date signed 3-10-47

X

G49170

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 94a

Registered No. G49170

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 69 Northship Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew J. Kogut

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-01-1699

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Married

6 (b) Name of husband or wife Marie Kogut

6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Oct 21 1901

8. AGE: Years	Months	Days	If less than one day
45	4	20	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Laundry-man

11. Industry or business Laundale Packing Co

FATHER
12. Name Michall Kogut
13. Birthplace Poland

MOTHER
14. Maiden Name Sophia Bialas
15. Birthplace Poland

16 (a) Informant Mrs. Marie Kogut
(b) Address 69 Northship Rd.

17 (a) Burial (b) Date thereof 3-13-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A Weber
(b) Address 705 E Oliver St

19 (a) MAR 11 1947 (b) Huntingtown Williams, Md
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10th 1947, at 8 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D.
Medical Examiner.
Date signed 3-10-47

VS 191

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49171

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G49171

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3640 Buena Vista Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Nettie B. Young

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	wh.	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 11 1882

8. AGE: Years	Months	Days	If less than one day
65	-	30	6 hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Jerry Bouldin

13. Birthplace Maryland

MOTHER 14. Maiden Name Jane " "

15. Birthplace Maryland

16 (a) Informant Mildred Walls

(b) Address 3640 Buena Vista Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 12/47 (month) (day) (year)

(c) Cemetery or crematory Butler

Location Baltimore Md.

18 (a) Funeral director Cheswell P. Donovan

(b) Address 3615-17 Chestnut Ave.

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

MAR 11 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1947, at 12 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 5 1947, to March 9 1947, and that I last saw h. alive on March 9 1947.

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to Hypertensive Cardio-vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hunter H. Williams M.D.

Address U.M.H. Date signed 3/9/47

X

B.C.G. 72644

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161a

Registered No. 049172

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Mercy Hospital
(b) Street address Calvert & Saratoga Ave.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2hr 34m.
(e) Length of stay in Baltimore (yrs., mos., or days) Same.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Mercy Hospital 1507 Eutaw St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Gaitley (Margaret P. Gaitley)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	W	Newborn

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 7, 1947

8. AGE: Years	Months	Days	If less than one day
—	—	—	2 hr. 34 min.

9. Birthplace Baltimore 2, Md. (Town, county, and state)
10. Usual Occupation Newborn
11. Industry or business —

FATHER
12. Name Edward Gaitley
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Margaret Hayes
15. Birthplace Baltimore Md.

16 (a) Informant Father Edward Gaitley
(b) Address 1507 Eutaw, Baltimore 2, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/11/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Ave.

18 (a) Funeral director George J. Ruth Inc
(b) Address 1735 Hoffard Ave

19 (a) (b)
(Date rec'd by registrar) Registrar

VS 158 Huntington Williams Md. MAR 11 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1947, at 2:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 7 1947 to March 8 1947 and that I last saw h[illegible] alive on March 8 1947.

Immediate cause of death Cardio-Respiratory Failure — Duration —

Due to Atelectasis, Bilateral Congenital — Duration 2hr 34m

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation —

of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature E. L. Tertipi M. D.
Address Mercy Hosp. Balt. 2, Md. Date signed Mar. 10 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49173

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1940

G49173 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4310 Maine Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4310 Maine Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOSEPH CHARLES HAUF, Sr.

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widower

6 (b) Name of husband or wife: Mary Agnes Hauf
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 22, 1870

8. AGE: Years	Months	Days	If less than one day
76	11	17	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired manufacturer
11. Industry or business

FATHER
12. Name Lewis Hauf
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Schnepff
15. Birthplace Germany

16 (a) Informant Mr. Joseph C. Hauf, Jr.
(b) Address 4204 Tuscany Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/12/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) (b) Registrar

MAR 11 Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9, 1947, at 4:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1947 to March 9 1947 and that I last saw him alive on March 9 1947

Immediate cause of death Lobular Pneumonia — Duration 2 days

Due to Cerebral Accident Ruptured Vessels — 5 days

Due to Coronary Infarct — 9 days

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Attorney in fact.
Address Med Arts Bldg Date signed March 11 1947 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49174

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G49174

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1925 Payson St.
(c) Hospital or institution: 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1925 Payson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BARBARA W. KEARNEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife William Joseph Kearney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 28, 1867

8. AGE: Years	Months	Days	If less than one day
79	10	10	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Beck
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace Germany

16 (a) Informant Miss Margaret Kearney
(b) Address 1925 Payson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/12/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Baltimore, Md.
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.
19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8, 1947, at 2:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1 1947, to 2/8 1947. and that I last saw her alive on 2/8 1947.

Immediate cause of death	Duration
Acute Cardiac Failure	Ida
Due to Generalized Arteriosclerosis	
Arteriosclerotic Cardiovascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dwight G Lankford MD
Address 1911 Washington Blvd Date signed 3/11/47 M. D.

VS MD MAR 11 1947

Huntington Williams, M.D.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49475

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G49475 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3408 Elgin Ave. 15
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3408 Elgin Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLEVELAND R. BEALMEAR

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	212-07-9031

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 25, 1884

8. AGE: Years	Months	Days	If less than one day
62	4	13 14	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Real Estate Broker
11. Industry or business

FATHER
12. Name James A. Bealmear
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Robinson
15. Birthplace Md.

16 (a) Informant Mr. James I. Bealmear, Jr.
(b) Address 3410 Elgin Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 11, 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH Mar. 8, 1947 at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1943 to March 6 1947. and that I last saw h[illegible] alive on Mch. 6 1947.

Immediate cause of death Acute Heart Failure — Duration Sudden
Due to Coronary Sclerosis
Due to Arteriosclerotic Hypertension
Other Conditions Ch. Nephritis.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jas McLean
Address 705 Mas Ave. Date signed 3/10/47 M D

VS 180 MAR 11 1947 Huntington Williams, M.D.

Jas. McLean X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G49176 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 647 N. Augusta Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Fitzgerald

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Alma (Kruse)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 13, 1886

8. AGE: Years	Months	Days	If less than one day
60	11	28	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Pipe Fitter
11. Industry or business Beth. Steel Co

FATHER
12. Name John J Fitzgerald
13. Birthplace Ireland

MOTHER
14. Maiden Name Nora Kenwick
15. Birthplace Ireland

16 (a) Informant Mrs Alma Fitzgerald
(b) Address 647 N. Augusta Ave

17 (a) Burial (b) Date thereof 3-13-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location

18 (a) Funeral director Harry H Witzke
(b) Address 4101 Edmondson Ave

19 (a) MAR 11 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/10 1947 at 12:50 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 3/10/47

G49177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G49177

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1533 W. Fayette Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PAUL A. PRIL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Willie M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22 1905

8. AGE: Years	Months	Days	If less than one day
41	8	14	hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Pril
13. Birthplace Germany

MOTHER
14. Maiden Name Pauline Bobka
15. Birthplace Germany

16 (a) Informant Mrs. Willie M. Pril
(b) Address 1533 W. Fayette St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 3-11-47 (month) (day) (year)
(c) Cemetery or crematory Moreland Cem.
Location Baltimore Co. Md.

18 (a) Funeral director Leonard J. Buck
(b) Address 5305 Harford Rd.

19 (a) (Date received by registrar) MAR 11 1947 (b) Huntington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8, 1947 at 7.05 P.M.

21. I certify that I took charge of the remains described above, held an insp. & inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Asphyxiation - shock

Due to all degrees of burns, involving 90 % of body surface

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/8/47 at approx. 6.30 p. M. 4/1
(b) Where did injury occur? Hanover & Lombard Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury auto collision followed by fire.

23. Signature Howard J. Weems M.D.
Medical Examiner.
Date signed 3-10-47

X

G49178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G49178 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 936 W. Fayette St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1d
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 936 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph McCoy

3 (b) If veteran, name war
3 (c) Social Security Account No. 216-10-9058

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Negro	married

6 (b) Name of husband or wife Ada McCoy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-7-87

8. AGE: Years	Months	Days	If less than one day
59	7	3?	hr. min.

9. Birthplace Westmoreland Co. Va. (Town, county, and state)
10. Usual Occupation Longshoreman
11. Industry or business

FATHER 12. Name Rhody McCoy
13. Birthplace Va.

MOTHER 14. Maiden Name Sarah Muse
15. Birthplace Va.

16 (a) Informant Mary Bass
(b) Address 936 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-13-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto., Md.

18 (a) Funeral director Charles L. Law
(b) Address 801 Mad. Ave.

MAR 11 1947 (Date rec'd by registrar)
(a) (b) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-9- 1947, at 1 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-1- 1947 to 3-9- 1947, and that I last saw h[illegible] alive on 3-9- 1947.

Immediate cause of death	Duration
Cardiac + Respiratory Failure.	
Due to Cardiac Failure Pneumonia	3 days. 3 day.
Due to	
Other Conditions Hypertension.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Huntington Williams M. D.
Address 2340 Madeira Date signed 3-10-47

X

G49179

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G49179

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun Sts.
(c) Hospital or institution:
Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 64 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1338 Hollins St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Leon Brooks

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	248-12-7162

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
M	W	

6 (b) Name of husband or wife Elizabeth (Nee Strickland)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17, 1882

8. AGE: Years	Months	Days	If less than one day
64	7	24	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Undertaker
11. Industry or business

FATHER
12. Name Robert Brooks
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Fehrens
15. Birthplace Maryland

16 (a) Informant Florence Brooks
(b) Address 17 S. Calhoun St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 13, 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Avenue

18 (a) Funeral director Walter Burpee Bradley
(b) Address 1922 W. North Avenue

19 (a) MAR 1 1947 (Date rec'd by registrar) (b) Registered Mar 13 1947

VS. 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1947, at 6 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 7 1947, to Mar. 11 1947, and that I last saw him alive on Mar. 11 1947

Immediate cause of death: Cardiac Decompensation — Duration: 2 yrs.

Due to: Renal Hypertension — 10 yrs.

Due to: Chronic glomerulonephritis

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stanley B. Klyanowicz M. D.
Address Franklin Square Hosp. Date signed 3-11-47

Dr F Bluck
715 Park Ave
#G19180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G19180

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 41 E Lexington St
(c) Hospital or institution:
Ardleigh Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 315 East 22nd Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice H. Gowman

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Widowed

6 (b) Name of husband or wife Dr. Corydon P.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 11, 1859

8. AGE: Years	Months	Days	If less than one day
88	0	28	hr. min.

9. Birthplace Minnesota
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Amos H. Norris
13. Birthplace Ohio

MOTHER
14. Maiden Name Isabell Fast
15. Birthplace Ohio

16 (a) Informant Mrs. Julia F. Mather
(b) Address 315 East 22nd Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-13-47 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Baltimore

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) 1947 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1947, at 11:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to March 9 1947, and that I last saw her alive on March 8 1947.

Immediate cause of death	Duration
Cerebral Vascular accident	4 days
Due to Arteriosclerosis	unknown
Hypertension	unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frances W. Bluck M. D.
Address 715 Park Ave Date signed 3/10/47

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93c

~~C49181~~ C49181

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave
(c) ~~Hospital~~ or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3818 Barrington Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louisa Ramhagne

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Female	White	Widowed

6 (b) Name of husband or wife Frederick L

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22-1863

8. AGE: Years	Months	Days	If less than one day
82	-	8 16	hr. min.

9. Birthplace Mich.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name "

15. Birthplace "

16 (a) Informant Geo. Netherton

(b) Address 2956 Wyman Pkwy

17 (a) Removal (b) Date thereof March 11 1947
(~~Burial~~, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Boy City.

Location Boy City Michigan

18 (a) Funeral director William Cook Inc

(b) Address 127 St Paul St

19 (a) 1947 (b) Livingston Williams MB
Registered by registrar Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 10th 1947, at 5 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 10, 1946, to Mar. 10, 1947, and that I last saw her alive on Mar. 9, 1947

	Duration
Immediate cause of death: Crebral Hemorrhage	3 days
Due to Arteriosclerosis	3 years
Due to Chronic Arthritis & Hyocarditis.	3 yrs.
Other Conditions Bilateral Cataracts (Include pregnancy within 3 months of death)	2 yrs.

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elliott G. Longwell M. D.

Address 613 E North Ave Date signed 3-11-47

B.C. G19182 G-12578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G49182
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 910 N. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby boy Hevener

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8, 1947

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Thomas Hevener
13. Birthplace Virginia

MOTHER
14. Maiden Name Isabelle Moore
15. Birthplace Virginia

16 (a) Informant Hospital Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 3/10/47
(burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glenbrook Md

18 (a) Funeral director Gilbert & Son
(b) Address 1217 E. Coul St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9. 1947 at 3:00A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 8 1947 to March 9 1947 and that I last saw him alive on March 9 1947

Immediate cause of death	Duration
Atelectasis due to prematurity.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Russell Jordan M. D.
Address Johns Hopkins Hospital Date signed 3-10-47

VS 150

HEALTH DEPARTMENT—CITY OF BALTIMORE

G49183 G49183

CERTIFICATE OF DEATH 1937

Registered No.....

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 5th Greenway Apartments Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 85 yrs. 0 mos. 11 ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

If U. S. Veteran specify WAR.....

2. FULL NAME Lyle Snyder Blair

(a) Residence: No. Greenway Apartments St., ... Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced: HUSBAND of (or) WIFE of Married

6. DATE OF BIRTH (month, day, year) March 1, 1862

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
85	0	11	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Home

10. Date deceased last worked at this occupation (month and year) March 1947

11. Total time (years) spent in this occupation 59

12. BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

FATHER

13. NAME Joseph F. Snyder

14. BIRTHPLACE (city or town) (State or country) Baltimore Maryland

MOTHER

15. MAIDEN NAME Louise Cunningham

16. BIRTHPLACE (city or town) (State or country) Baltimore Maryland

17. INFORMANT Alfred Eugene Blair

(Address) Greenway Apartments

18. BURIAL, CREMATION, OR REMOVAL

Place London Park Date 3/13 1947

19. UNDERTAKER Wilhoyte & Sons

(Address) 1214 E. Oval St.

20. FILED ..... 19.....

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) March 11, 1947

22. I HEREBY CERTIFY, That I attended deceased from January, 1940 to March 11, 1947

I last saw him alive on March 11, 1947. Death is said to have occurred on the date stated above, at 6.05 p.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Hypertensive Cardio-Vascular Disease	10 years
Cardiac Failure	2 Days

Other contributory causes of importance:

Was an operation performed? ..... Date of .....

For what disease or injury? .....

Name of operation .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased?

If so, specify .....

(Signed) W. Grafton Hershey M. D.

(Address) 214 Medical Arts Building

MAR 12 1947

Huntington Williams, M.D.

X

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be stated EXACTLY. PHYSICIANS should information should be carefully supplied. AGE should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G49184

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G49184

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 706 High Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John W. Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married.

6 (b) Name of husband or wife Eva Harris

6 (c) If alive, give age, years

7. Birth date of deceased (mo., day, yr.) December 25, 1894

8. AGE: Years	Months	Days	If less than one day
52	2	16	hr. min.

9. Birthplace Ga. (town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER
12. Name John W. Harris
13. Birthplace Ga.

MOTHER
14. Maiden Name Mckinney
15. Birthplace

16 (a) Informant Eva Harris = Wife
(b) Address 627 N. 42nd St. Phila Pa

17 (a) Shipment (Burial, cremation, or removal) (b) Date thereof 3/11/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Lawn Cem
Location Phila Pa.

18 (a) Funeral director Peter L. Gruff
(b) Address 1216 N. Carlisle St.

19 (a) MAR 11 1947 (Date rec'd by Registrar) (b) Interment or Removal

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10, 1947, at 4 A. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autppsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.

Date signed 3/10/47

VS 151

G49185

510332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46B

Registered No. G49185

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Johnstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. 947 Ash St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James B Gindlesberger.

3 (b) If veteran, name war

3 (c) Social Security Account No. 717-10-9074

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Sarah Gindlesberger
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) 7-13-84

8. AGE: Years	Months	Days	If less than one day
62.	7	28	..... hr. ..... min.

9. Birthplace Pa.
(Town, county, and state)
10. Usual Occupation Rail Road man
11. Industry or business Engineer

FATHER
12. Name Steven Gindlesberger
13. Birthplace Pa.

MOTHER
14. Maiden Name Livinia Thomas.
15. Birthplace Pa.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 3/11/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Johnstown, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) MAR 11 1947 (b) Huntingdon Williamsburg, Pa.
(Date received by registrar) (Registrar)

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1947, at 3.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 19. 1947. to March 11 1947, and that I last saw him alive on March 11 1947.

Immediate cause of death	Duration
Coronary Occlusion	6 d
Due to Carcinoma of Stomach with Liver Metastases	6 mo.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Mar 7, 1947
Major findings of operation: Inoperable carcinoma
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. Paul Huggins M.D.
Address Johns Hopkins Hosp. Date signed 11 Mar 47

G49186

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G49186
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 533 Campbell St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 533 Campbell St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Frank Basnite (BASNIGHT)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-24-1905

8. AGE: Years 41 | Months 10 | Days 16 | If less than one day hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER
12. Name Ellis Basnight
13. Birthplace N. C.

MOTHER
14. Maiden Name Ellen Midgett
15. Birthplace N. C.

16 (a) Informant Roscoe Basnight
(b) Address 614 Perkins St

17 (a) Burial (b) Date thereof 3 12 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director William A Jackson
(b) Address 916 Penna ave

19 (a) MAR 14 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1947, at 10:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl A Royer M.D.
Medical Examiner.
Date signed 3-13-47

G49187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G49187 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1426 Mosher St
(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1426 Mosher St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jackson Allen

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	Married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 3-9-1877

8. AGE: Years	Months	Days	If less than one day
69.	11	26 29	hr. min.

9. Birthplace ? (town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Mary Allen
(b) Address 1426 Mosher st

17 (a) Burial (b) Date thereof 3 12 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Laurel Cem
Location Baltimore Md

18 (a) Funeral director Stephens G Parker
(b) Address 916 Pennsylvania ave

19 (a) (Date rec'd by registrar) (b) Huntington Mills Registrar

MAR 11 1947

YS 490

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 19 , at 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-3- 1947 to 3-7- 1947 and that I last saw h alive on 3-7- 1947

Immediate cause of death Chronic myocarditis — Duration

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature C R Campbell M. D.
Address 718 Dolphin St Date signed 3-11-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49188
CWK-95971

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G49188

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [redacted] 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 5- 28-
(e) Length of stay in Baltimore (yrs., mos., or days) 37- 0- 18-

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town Linthicum Heights-Maryland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 801 [redacted] CAMP MEADE RD.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Ziemba

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Frank
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 20-1910

8. AGE: Years	Months	Days	If less than one day
37	0	18	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation HOUSE-WORK.
11. Industry or business AT HOME.

FATHER
12. Name William Pozniak (D)
13. Birthplace Poland

MOTHER
14. Maiden Name Mary Scott (D)
15. Birthplace Poland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3-12-47 (month) (day) (year)
(c) Cemetery or crematory ST. STANISLAUS CEM.
Location DUNDALK AVE.

18 (a) Funeral director Charles S. Zeiler
(b) Address 3605 Fait Ave.

19 MAR 11 1947 (Date rec'd by registrar) (c) Huntington Williams, M.D.

MEDICAL CERTIFICATION P

20. DATE OF DEATH March 8 1947, at 8:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 10 1945 to Mch. 8 1947 and that I last saw h[er] alive on Mch. 8 1947.

Immediate cause of death Pulmonary Tuberculosis — Duration
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 2-22-47
Major findings of operation: Thoracic, ? pleural adhesions
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice M. Lans M. D.
Address Baltimore City Hos. Date signed 3-8-47

VS 150

G19189

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G19189
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hosp. V
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3424 Fait Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry L. B. Mangels

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-05-5635

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Annie C. Mangels
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13, 1879

8. AGE: Years	Months	Days	If less than one day
67	8	27	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Continental Can Co.

FATHER
12. Name Henry Mangels
13. Birthplace Baltimore

MOTHER
14. Maiden Name Elizabeth
15. Birthplace Germany

16 (a) Informant Wife
(b) Address 3424 Fait Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-13-47. (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Eastern Ave.

18 (a) Funeral director Charles L. Zeiler
(b) Address 3605 Fait Ave.

19 (a) MAR 11 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1947, at 9:55 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Valvular heart disease

Due to

Other Conditions generalized arterio-sclerosis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl Royer M.D.
Medical Examiner.
Date signed 3-10-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G49190 — 1937 — Registered No. 63830

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Street
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Phillips Jr

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Lillian
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-13-15

8. AGE: Years	Months	Days	If less than one day
31	7	28	hr. min.

9. Birthplace Md - Pa. (Town, county, and state)
10. Usual Occupation - Taxi Driver
11. Industry or business

FATHER
12. Name George Phillips
13. Birthplace Pa

MOTHER
14. Maiden Name Lillian Hoffman
15. Birthplace Pa

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 14 1947 (month) (day) (year)
(c) Cemetery or crematory Hubley Cem.
Location Harford Co. Md

18 (a) Funeral director H. S. Bailey
(b) Address Darlington, Md

19 (a) (Date rec'd by reg.) MAR 11 1947 (b) Registrar Huntington Mitchell M.D.

VS 190

MEDICAL CERTIFICATION

53

20. DATE OF DEATH March 10, 1947 at 4 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1947 to March 10 1947 and that I last saw him alive on March 10 1947.

Immediate cause of death ACUTE CARDIAC FAILURE — Duration 8 HOURS

Due to HYPERTENSIVE CARDIOVASCULAR DISEASE WITH UREMIA — Duration

Due to AND UREMIC PERICARDITIS — Duration ? YEAR

Other Conditions PERICARDIAL AND PLEURAL EFFUSIONS
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy: AS ABOVE. CONTRACTED KIDNEYS

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Maxwell Williamson M. D.
Address John Hopkins Hospital Date signed 3-10-47

X

Birth Certificate

G49191 B-23696

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G49191

1614

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: President Hosp.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1514 Division (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kenneth Earl Baylor
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex male | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife none | 6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 3/6/47
8. AGE: Years | Months | Days 3 | If less than one day hr. min.
9. Birthplace 1514 Division (Town, county, and state) Provident Hosp
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Solomon Baylor
13. Birthplace King Williams, Va.

MOTHER
14. Maiden Name Thelma Robinson
15. Birthplace Dover, D. C.

16 (a) Informant Mr. Solomon Baylor
(b) Address 909 N. Mc Mean Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 11, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

vs MAR 11 1947 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/9 1947 at 5 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/6/47 to 3/9/47.
and that I last saw h alive on

Immediate cause of death
Pulmonary Thrombosis
Due to
Due to Pleurisy
Other Conditions

Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Holland M. D.
Address 1631 Harlem Ave Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

G49192 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2401 Foster Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard Gladkowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/5/31

8. AGE: Years	Months	Days	If less than one day
15	5	5	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER
12. Name Felix Gladkowski
13. Birthplace Poland

MOTHER
14. Maiden Name Aleksandra Sobetka
15. Birthplace Poland

16 (a) Informant Mrs. Aleksandra Gladkowski
(b) Address 2401 Foster Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/13/47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Gorsuch Mill Rd.

18 (a) Funeral director John J. Fisher
(b) Address 401 S. Chester St.

19 (a) (Date rec'd by registrar) (b) Registrar

vs MAR 11 1947 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/10 1947, at 4:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/3 1947 to 3/10 1947 and that I last saw h. alive on 3/10 1947

Immediate cause of death	Duration
Peritonitis	
Due to Patent Appendix	
Stump	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 3/5/47

Major findings of operation: Perforated Gangrenous Appendix

of autopsy: Peritonitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert H. Young M. D.
Address 1 N. Gay St. Date signed 3/13/47

Zygaj - Sigai

G49193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

G49193 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1115 S. Potomac
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto (If not in city or town limits, write RURAL and give town)
(d) Street No. 1115 S. Potomac (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Michalina Zygaj or Lena Sigai

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Femal

5. Color or race White

6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Josef Zygaj or Sigai

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 26 1881

8. AGE: Years 65 | Months 5 | Days 13 | If less than one day ____ hr. ____ min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Szafanska
13. Birthplace Poland

MOTHER
14. Maiden Name Madeline
15. Birthplace Polond

16 (a) Informant Mr. Jozef Zygaj or Sigai
(b) Address 1115 S. Potomac

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 12 47 (month) (day) (year)
(c) Cemetery or crematory Stanislaus Cem
Location

18 (a) Funeral director Marie E. Fratkowski
(b) Address 4000 E. Kenwood ave

19 (a) 1947 (Date registered) (b) Thomas Jefferson Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1947 at 4:30 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1946 to Mar 8 1947 and that I last saw h[illegible] alive on Mar 8 1947

Immediate cause of death Myocardial Failure — Duration 1 day

Due to Arteriosclerosis, Generalized — 8 yrs.

Due to Arterial Hypertension — 1 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clarence W. LeBoeuf M. D.
Address 601 S Ellwood Ave Date signed 3/10/47

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49194

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G49194

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 3/4 mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 205 N. Amity St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE:	Years	Months	Days	If less than one day
	65			hr. min.

9. Birthplace Portsmouth, Va (Town, county, and state)

10. Usual Occupation Unemployed.

11. Industry or business

FATHER — 12. Name David Johnson

13. Birthplace Portsmouth Va.

MOTHER — 14. Maiden Name Georgia Johnson

15. Birthplace Va.

16 (a) Informant Minnie Sykes

(b) Address 743 W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/11/47 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Washington Witherspoon, M.D.

VS MAR 11 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1947, at 1.50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 8, 1946 to March 5, 1947 and that I last saw him alive on March 5, 1947

Immediate cause of death	Duration
Congestive Heart Failure	
Due to Generalized Arteria-Sclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Sapp M. D.

Address Univ. Hospital, Balto. Date signed 3-5-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB- 107456 C494/95

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 138

Registered No. 648/95

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo. 22days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 222 Slemmers Alley
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Moulds

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 18- 1868

8. AGE: Years	Months	Days	If less than one day
78	2	13	hr. min.

9. Birthplace N.J.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 4- 1947
(Month) (day) (year)
(c) Cemetery or crematory St. Agatha's
Location Edmondson Ave.

18 (a) Funeral director Wendell Hippel
(b) Address 312 S. Highland Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 11 1947

VS 100 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1- 1947, at 8:10AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-9 1947 to 3-1- 1947 and that I last saw h. in alive on 3-1- 1947

Immediate cause of death Pulmonary Hem. Duration 6 hrs +

Due to

Due to

Other Conditions Arteriosclerosis.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Hunt M. D.
Address Balt. City Hosp. Date signed 3-1-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19496 | BALTIMORE CITY HEALTH DEPARTMENT | G19496

CERTIFICATE OF DEATH 43a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 N Hilton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2203 Windsor Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mattie F McFaul

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife late George E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25 1863

8. AGE: Years	Months	Days	If less than one day
83	9	15	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John B Lehmicd
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Leety
15. Birthplace Germany

16 (a) Informant Mrs Mildred Nicol
(b) Address 2203 Windsor Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 12 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave

18 (a) Funeral director Harry W Wilhelm
(b) Address 4101 Edmondson Ave

19 (a) Date rec'd by registrar Watkins-Williams, Mgrs Registrar

VS MAR 11 1947

MEDICAL CERTIFICATION A.

20. DATE OF DEATH March 10 1947, at 5:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 6, 1947, to Mar. 10, 1947. and that I last saw her alive on Mar. 9, 1947.

Immediate cause of death	Duration
Cerebral hemorrhage & paralysis	2 days
Due to Advanced arterio-sclerosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) ~~Accident, suicide, or homicide~~
(b) Date of occurrence at M
(c) ~~Where did injury occur?~~ (City or town) (County) (State)
(d) ~~Did injury occur about home, on farm, industrial~~ place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. F. Nevin M. D.
Address 2226 Harlem Date signed

Dead X 3/11/47

G49497
508861

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

Registered G49497

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3228 Kingsley St. (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Melvin L. Barton

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-14-4357

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 12-18-21

8. AGE: Years	Months	Days	If less than one day
26	2	21	..... hr. ..... min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Commercial Artist

11. Industry or business

FATHER
12. Name Charles Barton
13. Birthplace Md

MOTHER
14. Maiden Name Marie Spies
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 13 1937 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location 4300 Old Frederick Rd

18 (a) Funeral director Harry A. Wetzel
(b) Address 4101 Edmondson Ave.

19 (a)..... (Date rec'd by registrar) (b)..... Registrar

VS 150

Huntington Williams

MAR 11 1937

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 9 1937, at 8:12 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 14 1937 to Mar 9 1937 and that I last saw him alive on Mar 9 1937

Immediate cause of death	Duration
CEREBRAL HEMORRHAGE	14 HRS.
Due to HYPERTENSIVE CARDIOVASCULAR DISEASE	± 5 YRS.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operations:.....

of autopsy: AS ABOVE - SMALL CONTRACTED KIDNEYS

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature J. Maxwell Williams M. D.
Address Johns Hopkins Hospital Date signed 3-9-37

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G49498

G49498

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1838 W. Saratoga St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 1838 W. Saratoga St. (If rural give location)
(e) Citizen of foreign country? (Yes or No?) If yes, name country

3 (a) FULL NAME George W. Wise

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Married

6 (b) Name of husband or wife Sarah J. Lee Shipley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 5, 1862

8. AGE: Years	Months	Days	If less than one day
84	3	4	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name — Wise
13. Birthplace Va.

MOTHER
14. Maiden Name Sarah Ann Shackelford
15. Birthplace Va.

16 (a) Informant Walter C. Wise
(b) Address 3001 Elgin Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/12/47. (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director Harry H. Wittle
(b) Address 4101 E. Monument Ave.

19 (a) (Date rec'd by registrar) (b) Registrar, M. D.

V S 150

MAR 11 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/9/47. 19 , at 6:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/10 1947 to 3/9 1947, and that I last saw h alive on 3/8 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	5 hrs
Due to Edema	
Due to	
Other Conditions Myocarditis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature James W. Greenberg M. D.
Address 725 Melvin Ave. Date signed 3/10/47

83a

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

C49499 (Registered No.)

C49499

MARGIN RESERVED FOR BINDING

Every item of information should be carefully supplied. The write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 523 Wildwood Pkwy (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. John A. Flynn

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Married

6 (b) Name of husband or wife Anna R. Flynn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 14, 1882

8. AGE: Years	Months	Days	If less than one day
65	1	26	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation B. & O. R. R.
11. Industry or business

FATHER
12. Name James Flynn
13. Birthplace Md

MOTHER
14. Maiden Name Unknown
15. Birthplace Md.

16 (a) Informant Mrs. John A. Flynn
(b) Address 523 Wildwood Pkwy

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/13/47. (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location 3801 Frederick Rd

18 (a) Funeral director Harry A. Guthe
(b) Address 4101 E Lanvondale Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MAR 1 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 March 1947, at 6 30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 5 Mar 1947 to 10 Mar 1947 and that I last saw h[illegible] alive on 10 Mar 1947.

Duration

Immediate cause of death Respiratory failure
Due to Subarachnoid intracranial hemorrhage
Due to Hypertension & arteriosclerosis
Other Conditions Emphysema
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. Leary M. D.
Address University Hosp. Date signed 3-10-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43600

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G43500

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MARYLAND GENERAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) ~~10 days~~

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 817 Hamilton Terrace (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HOVHANNES K. PELTEKIAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
Spanish + World War II	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband ~~or wife~~ Lucinda Stone
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 1871

8. AGE: Years	Months	Days	If less than one day
75	7		hr. min.

9. Birthplace Armenia (Town, county, and state)
10. Usual Occupation Physician
11. Industry or business

FATHER
12. Name Kevork Peltekian
13. Birthplace Armenia

MOTHER
14. Maiden Name Sepatjain
15. Birthplace Armenia

16 (a) Informant Mrs William Holeshko
(b) Address 817 Hamilton Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 17/47 (month) (day) (year)
(c) Cemetery or crematory Arlington National
Location Arlington Va

18 (a) Funeral director Harry H. Lutzke
(b) Address 4401 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/8 1947, at 8:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/7 1947 to 3/8 1947, and that I last saw him alive on 3/8 1947.

Immediate cause of death CORONARY OCCLUSION — Duration 1 DAY

Due to CORONARY ARTERY ARTERIOSCLEROSIS

Due to

Other Conditions POSSIBLE CEREBRAL VASCULAR DISEASE (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles W. Stewart, Jr. M. D.
Address MD. GEN. HOSP. Date signed 3/8/47

VS 150

X

501 BC# D 12990

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161a

Reg. No. 6950

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 14 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2711 Spelman Rd. Cherry Hill
(If rural give location)
(e) Citizen of foreign country? Md (Yes or No)
If yes, name country

3 (a) FULL NAME Stephanie Karen Butler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 27, 1947

8. AGE: Years | Months | Days | If less than one day: 14 hrs. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation

11. Industry or business —

FATHER
12. Name Aaron Butler
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Jennie Franklin
15. Birthplace Balto. Md

16 (a) Informant Jennie Butler
(b) Address 2711 Spelman Rd.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School MAR 11 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 11 1947 (Date received by Registrar) Hunter H. Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28, 1947, at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 27 1947, to Feb. 28 1947, and that I last saw her alive on Feb. 28, 1947.

Immediate cause of death: Atelectasis — Duration

Due to: Aspiration of placenta & amniotic fluid

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis Foger M. D.
Address Date signed

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important. Use necessary supplementary sheet.

VS 150

3/10/47

G19502

BALTIMORE CITY HEALTH DEPARTMENT

Registered No. G19502

Blk G66258

CERTIFICATE OF DEATH 1576

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address ~~1518 Harlem Ave~~

(c) Hospital or institution: Provident Hosp. 1514 Division St.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 918 Harlem Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Joyce Ann Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe	Negro	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-18-46

8. AGE: Years	Months	Days	If less than one day
	1	20	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Wilson Edward Miller

13. Birthplace Spartanburg S.C.

MOTHER — 14. Maiden Name Lennell Bowen

15. Birthplace Spartanburg S.C.

16. (a) Informant Lennell Miller

(b) Address 918 Harlem Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location Johns Hopkins Medical Schoo MAR 11 1947

18 (a) Funeral director Commissioner of Health

(b) Address

19 MAR 11 1947 (Date rec'd by registrar) (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6, 1947, at 11 25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-18-46 19 to 2-6- 1947, and that I last saw h[illegible] alive on 2-6- 19 47.

Immediate cause of death	Duration
Malnutrition	
Due to Spina bifida	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [illegible] M. D.

Address [illegible] Date signed

X 2/3/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

503 B.C.G.-7269 BALTIMORE CITY HEALTH DEPARTMENT G49503
CERTIFICATE OF DEATH 159 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 West Fayette St.
(c) Hospital or institution: Bon Secours Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 hr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 124 S. Collington ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Girl Saunders

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	

6 (b) Name of husband or wife Mary Saunders
6 (c) If alive, give age 21 years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			5 hr. 0 min.

9. Birthplace Bon Secours Hospital Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Audie Saunders
13. Birthplace Wayne West Virginia

MOTHER
14. Maiden Name Mary Emerick
15. Birthplace Jeffersonsburg Penn.

16 (a) Informant Audie Saunders
(b) Address 124 S. Collington Ave Balto.

17 (a) (Burial, cremation, or removal) (b) Date thereof 3 · 10 · 47 (month) (day) (year)

(c) Cemetery or crematory Johns Hopkins Medical Schoo
Location

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 11 1947 (b) Huntington Williams M.D.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1947, at 2:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 7 1947, to March 7 1947, and that I last saw h-- alive on March 7 1947.

Immediate cause of death	Duration
Respiratory failure prematurity	
Due to Intracranial hyaline amnion, edema	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hilliam B Carr M. D.
Address Bon Secours Hosp Date signed 3-10-47

VS 150

G19504 G19504 ✓

5 11 200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X 92D

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address.....

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days).....

(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County A.A. Co.

(c) City or town Annapolis (If outside city or town limits, write RURAL and give town)

(d) Street No. RFD 2 Box 392 (If rural give location)

(e) Citizen of foreign country?.....(Yes or No)

If yes, name country.....

3 (a) **FULL NAME** William Henry Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	✓

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1-25-86

8. AGE: Years	Months	Days	If less than one day
61	1 -	- 16	..... hr. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business -

FATHER

12. Name Henry Johnson

13. Birthplace Md

MOTHER

14. Maiden Name Mary Ireland

15. Birthplace Md

16 (a) Informant Records JOHNS HOPKINS HOSPITAL

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 16/47 (month) (day) (year)

(c) Cemetery or crematory Broadneck

Location St Margretts, A.A.Co.

18 (a) Funeral director J.B. Johnson

(b) Address Annapolis

19 (a)..... (Date rec'd by registrar) (b) Keating for Wilkinson Registrar

MAR 11 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 10 1947 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 6 1947 to Mar 10 1947 and that I last saw h[illegible]live on Mar 10 1947

Immediate cause of death Arteriosclerotic heart dis — Duration 6 yrs

Due to.....

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation.....

of autopsy: as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide.....

(b) Date of occurrence..... at ..... M

(c) Where did injury occur?..... (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)

(e) Means of injury.....

23. Signature Robert E. Mason M. D.

Address Johns Hopkins Hosp. Date signed 10 Mar 47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C13505

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. C13505

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Monument & Rutland Ave.
(c) Hospital or institution: Siani Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days): 6
(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 120 N. Montford Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME Irvin Bennett (Irvin R. Bennett)

3 (b) If veteran, name war: --

3 (c) Social Security Account No.: 219-01-2810

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Myrtle Bennett

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 6, 1900

8. AGE: Years: 47 Months: 1 Days: 5 If less than one day: hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual Occupation: Machinist

11. Industry or business: American Oil Co.

FATHER
12. Name: John Bennett
13. Birthplace: Balto. Md.

MOTHER
14. Maiden Name: Minnie Potzer
15. Birthplace: Balto. Md.

16 (a) Informant: Mrs. Myrtle Bennett
(b) Address: 120 N. Montford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Mar. 14/47 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet Cem.
Location: Balto. Md.

18 (a) Funeral director: Philip Sterling Sons
(b) Address: 2024 Orleans St.

19 (a) (Date rec'd by local reg.) MAR 12 1947 (b) Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 11, 1947, at 12:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 10 1947 to March 11 1947, and that I last saw him alive on March 10 1947.

	Duration
Immediate cause of death: Pneumonia	
Due to:	
Due to:	Post
Other Conditions:	
(Include pregnancy within 3 months of death)	
Date of operation:	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Leo Rosenbaum Jr. M. D.
Address: Siani Hosp. Date signed: 3/11/47

Spec.—1-10-21—M&T—1500 Blks.

G49506 ✓ G49506

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 16

G49506

REGISTERED NO.

1-PLACE OF DEATH Kernan Hospital-

CITY OF BALTIMORE: (No. Baltimore 7, Md ST., ✓ WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernestine Logan - C 4

(a) RESIDENCE NO. 1500 argyle avenue ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F-	Negro-	Single-

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 29, 1944

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	8	8 10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Carolina

PARENTS

10 NAME OF FATHER Ernest Logan

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C

12 MAIDEN NAME OF MOTHER Frances Crawford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C

14 Informant Katie Green (Address) 1338 N. Fremont Ave

15 Filed MAR 12 1947 Huntington Williams M.H. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9 March 1947

17 I HEREBY CERTIFY, That I attended deceased from 23 October, 19 46, to 9 MARCH, 1947, that I last saw h[illegible] alive on 9 MARCH, 1947, and that death occurred, on the date stated above, at 7 30 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of meninges

(duration) 0 yrs. 0 mos. 24 ds.

CONTRIBUTORY (Secondary) Tuberculosis of Vertebrae 12 dorsal to 3rd lumbar inclusive (duration) 1 yrs. 2 mos. ? ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) L. Ralph Terhune, M. D.

MAR 9. 1947 (Address) Kernan Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn cem.

DATE OF BURIAL 3-12 1947

20 UNDERTAKER George G. Nelson

ADDRESS 1303 Pennsylvania Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN'S NAME should be signed EXACTLY. PHYSICIAN'S ADDRESS should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

64507

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

64507 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 18 W 21st St D.H.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 18 W 21st St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** (Osear) Pecar Braxton

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1857 1858

8. AGE: Years	Months	Days	If less than one day
89			hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name D. Braxton
13. Birthplace Va.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Richard Braxton
(b) Address 1317 N. Stricker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/9/47 (month) (day) (year)
(c) Cemetery or crematory Greenmount Mt Auburn
Location Md

18 (a) Funeral director Geo. B. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) MAR 12 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/10 1947, at 12:25 M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V.D.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Subranke M.D.
Medical Examiner.
Date signed 3/12/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G19508

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

Registered No. G19508

MARGIN RESERVED FOR ... PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital. 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1727- Edmondson Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie Davis (Shields)

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Garold Davis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/10/25

8. AGE: Years 21 22 | Months 10 | Days 29 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Charles Shields

13. Birthplace Va

MOTHER 14. Maiden Name Virginia Davis

15. Birthplace Va.

16 (a) Informant Virginia Shields

(b) Address 1727 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/12/47 (month) (day) (year)

(c) Cemetery or crematory Arlington

Location Md

18 (a) Funeral director Lee H. Nelson

(b) Address 1303 Freemason St

19 (a) MAR 12 1947 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9, 1947, at 1.20 a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of heart, liver, lungs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 3-9-47 at 1 a. M.

(b) Where did injury occur? Inside cafe- Penna. Ave & Pitcher Street

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Firearms

23. Signature Homer A. Mueseis M.D. Medical Examiner.

Date signed 3-10-47

VS 181

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49509

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

Registered No. G49509

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution: St. Joseph's Hospital W 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 239 S. Highland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Charles L. Greenfelder
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Mary Louise Fischer
6 (c) If alive, give age – years

7. Birth date of deceased (mo., day, yr.) July 20 1879

8. AGE: Years	Months	Days	If less than one day
67	7	21	hr. min.

9. Birthplace Balto, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business –

FATHER 12. Name Henry Greenfelder
FATHER 13. Birthplace Germany
MOTHER 14. Maiden Name Mary Middlefinger
MOTHER 15. Birthplace Balto. Md.

16 (a) Informant Mrs. Mary Greenfelder
(b) Address 239 S. Highland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/14/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director John D Connelly
(b) Address 418 Eastern Ave. East 21

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 12 1947 Kuntzleman for Willis

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/10 1947, at 4:58 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/17 1947 to 3/10 1947, and that I last saw him alive on 3/10 1947

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Post operative pneumonia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 2/26/47 & 3/6/47

Major findings of operation: Bronchiectasis, Pleurisy, Sigmoid + bladder

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan D. Owen M. D.
Address 25 E. Lexington Date signed 3/12/47

X

G12510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G12510

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1604 N. Pulaski St

(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1604 N. Pulaski St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Meyer Sacks

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of ~~husband or~~ wife Ella

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 69 | Months — | Days — | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Plumber

11. Industry or business

FATHER

12. Name Abraham Sacks

13. Birthplace Russia

MOTHER

14. Maiden Name Gittel Sarah

15. Birthplace Russia

16 (a) Informant Ella Sarah Sacks

(b) Address 604 Pulaski St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-12-47 (month) (day) (year)

(c) Cemetery or crematory Hebrew Herzog Rem

Location

18 (a) Funeral director Jack Lewis Inc

(b) Address 1429 E Balto St

19 (a) Huntington Williams, M.D. Registrar

(Date received by registrar) MAR 12 1947

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1947 at 8 a.m. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1947 to March 11 1947 and that I last saw him alive on March 9 1947.

Immediate cause of death Cerebral hemorrhage — Duration

Due to

Due to

Other Conditions Arterio Sclerosis

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Benjamin Kaden M. D.

Address 2306 Eutaw Pl Date signed 3-11-47

X

19511

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. G19511

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2006 Linden Ave
(c) Hospital or institution: 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 27yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2006 Linden Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frieda Berg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Alexander

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years: 49 | Months | Days | If less than one day: hr. min.

9. Birthplace Bucarabia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Hyman
13. Birthplace Romania

MOTHER
14. Maiden Name unknown
15. Birthplace Romania

16 (a) Informant Alexander Berg
(b) Address 2006 Linden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-12-47 (month) (day) (year)
(c) Cemetery or crematory Mod Kev Israel
Location Southern ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1429 E Balto St

19 (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-11- 1947 at 1? M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/25 1946 to 3/11 1947
and that I last saw her alive on 3/11 1947

Immediate cause of death: Gynal metastasis — Duration: 6 mo

Due to Carcinoma rectum — ?

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank Lerman M. D.
Address 2006 Linden Av Date signed 3/11/47

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49512

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G49512

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 645 S. Belnord Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony Bekus (Byczkowski)

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-1566

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Marie Bekus
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Operator
11. Industry or business Baltimore Transit

FATHER
12. Name Unknown
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Poland

16 (a) Informant Marie Bekus Byczkowski
(b) Address 645 S. Belnord Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-14-47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location German Hill Rd

18 (a) Funeral director John J. Duda
(b) Address 2239 Hudson St

19 (a) MAR 12 1947 (Date rec'd by reg'r) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-10- 1947, at 6:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Dec death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D. Medical Examiner.
Date signed 3/11/47

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G42513

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G42513 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1807 N.Castle Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 N.Castle Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Frederick H.A.Nily

3 (b) If veteran, name war: No
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mamie Nily
6 (c) If alive, give age yrs.
7. Birth date of deceased (mo., day, yr.) Jan. 10, 1875

8. AGE: Years	Months	Days	If less than one day
72	2	0	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Shipping Clk.
11. Industry or business Crist Transfere Co.

FATHER
12. Name Frederick Nily
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary B.Zimmerman
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Mamie Nily (Wife)
(b) Address 1807 N.Castle Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-13-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Frederick Rd.Baltimore, Md

18 (a) Funeral director Albert L. Nilly Jr
(b) Address 1606 N.Chester Street

19 (a) MAR 12 1947 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 10 1947 at 5 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1946 to Mar 10 1947 and that I last saw h[illegible] alive on Mar 10 1947

Immediate cause of death	Duration
Generalized carcinomatosis	
Due to Ca of small intestine	
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Conrad L. Pettit M.D.
Address 706 N. Wash[illegible] St. Date signed 3/11/47

Huntington Hill M.D.

(over)

X

G49514 G49514

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83B

Registered No. G49514

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 W. Cold Spring Lane
(c) Hospital or institution: Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1927 E. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry B. Lewis

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	212-18-9707

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Jennie Lewis
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Sept 9, 1878

8. AGE: Years	Months	Days	If less than one day
68	6	5 2	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Sexton of Church
11. Industry or business

FATHER
12. Name Henry Lewis, Sr.
13. Birthplace —

MOTHER
14. Maiden Name Helen Larkins
15. Birthplace —

16 (a) Informant Mrs. Helen Stickler
(b) Address 3034½ Pinewood Ave

17 (a) Burial (b) Date thereof 3/13/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Taylor Ave

18 (a) Funeral director Howard N. Bright Jr.
(b) Address 6009 Harford Road

MAR 12 1947 (b) Huntington Williams M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1947 at 7.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 15 1946, to March 11 1947, and that I last saw him alive on March 10 1947.

Immediate cause of death	Duration
Bronchopneumonia.	4 days
Due to Cerebral Thrombosis	6 Mo.
Due to Generalized Arteriosclerosis	Yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norman R Kleiman M. D.
Address 3803 Edmondson Ave Date signed 3/11/47

G19515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G19515

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1108 N. Montford Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1108 N. Montford Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John W. Dawson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary A. B. Dawson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 6 1871

8. AGE: Years 76 | Months 11 | Days 5 | If less than one day hr. min.

9. Birthplace: Baltimore (Town, county, and state)
10. Usual Occupation: Mechanic
11. Industry or business: Penna Ry

FATHER
12. Name: John Dawson
13. Birthplace: Md

MOTHER
14. Maiden Name: Mary McClene
15. Birthplace: Scotland

16 (a) Informant: Miss Florence Dawson
(b) Address: 1108 N Montford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 14 (month) (day) (year)
(c) Cemetery or crematory: Cedar Hill Cem
Location: Rural

18 (a) Funeral director: Ullrich Funeral Home
(b) Address: 2005 Abram St

19 (a) Date received by Local Reg. MAR 12 1947 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 11th 1947, at 1 50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1947 to Mar. 11 1947 and that I last saw him alive on Mar. 11 1947.

Immediate Cause of death: Thrombosis Coronary
Due to: Arteriosclerotic Cardio-Vascular Disease
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: 6 hrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: L. B. Stevens, M.D.
Address: 3400 Edmondson Ave Date signed: 3/14/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

510917 G49516 BC# 647090

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

14

Registered No. G49516

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4 So. York St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Elizabeth Sexton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-24-45

8. AGE: Years	Months	Days	If less than one day
1	15 3	17	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Roman Wm Sexton
13. Birthplace Md.

MOTHER
14. Maiden Name Grace V Trigger
15. Birthplace Md.

16 (a) Informant Rhonda
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/14/47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Annapolis Road

18 (a) Funeral director John F Henry Inc
(b) Address 711 Light St.

19 (a)..... (Date rec'd by registrar) (b)..... Registrar

VS 190
MAR 12 1947

MEDICAL CERTIFICATION A

20. DATE OF DEATH March 11 1947, at 1.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 2 1947, to March 11 1947 and that I last saw her alive on March 11 1947.

Immediate cause of death Tuberculous meningitis — Duration

Due to.....

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at.....M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature Hubert Rammond M. D.
Address Johns Hopkins Hosp Date signed 3-11-47

X

G49517

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G49517

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3105 Windsor ave.
(c) Hospital or institution: 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3105 Windsor ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME TERESA FORTMAN

3 (b) If veteran, name war ---
3 (c) Social Security Account No. ---

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Henry Fortman
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 28, 1859
8. AGE: Years 87 | Months 3 | Days 13 | If less than one day hr. min.
9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name John Adam Neus
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Huber
15. Birthplace Germany

16 (a) Informant Mrs. Teresa Pfaff
(b) Address 3105 Windsor ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/14/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair road

18 (a) Funeral director Chas. J. Evans & Son
Address 411 N. Mt. Royal Ave

19 (a) MAR 12 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1947, at 6 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. ? 1943, to March 10 1947 and that I last saw her alive on 3-10 1947.

Immediate cause of death: arteriosclerotic Cardio-vascular disease — Duration: many years

Due to

Due to

Other Conditions: moderate arteriosclerotic senile dementia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature William J Sullivan M. D.
Address 2911 Garrison Blvd Date signed 3-11-47

Registrar Washington Netterville, M.D.

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G49518 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address **********
(c) Hospital or institution: Franklin Square Hospital. 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1202- W. Fayette St. (roomer)
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN C. GILMORE

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	UNKNOWN

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Unknown
11. Industry or business

FATHER
12. Name James Gilmore
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Jennie ?
15. Birthplace Baltimore, Md.

16 (a) Informant Thomas G. Young
(b) Address Calvert Bank Howard at Saratoga st.

17 (a) Burial (b) Date thereof 3/12/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location

18 (a) Funeral director Chas J. Evans Son Inc
(b) Address 118 N. Mt. Royal Ave.

19 (a) 3 12 1947 (b)
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10, 1947, at 10. AM

21. I certify that I took charge of the remains described above, held an insp. & inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute congestive heart failure

Due to Generalized arteriosclerosis

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earle L. Royer M.D.
Medical Examiner.
Date signed 3-10-47

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43519

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G43519 Registered No. 477

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton Ave
(c) Hospital or institution: St Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Lansdowne (If outside city or town limits, write RURAL and give town)
(d) Street No. 105 Fifth Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Miles

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Minnie K. Miles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 30 1880

8. AGE: Years	Months	Days	If less than one day
62	2	11	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Track - B&O RR
11. Industry or business

FATHER	12. Name John Miles
	13. Birthplace Md
MOTHER	14. Maiden Name Annie Schmidt
	15. Birthplace Md

16 (a) Informant Minnie K. Miles
(b) Address 105 - 5th Ave Lansdowne

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-14-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto City

18 (a) Funeral director Edw. L. Mac Nabb
(b) Address Catonsville - 28 Md

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 MAR 12 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/10 1947, at 8:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/3 1947 to 3/10 1947, and that I last saw h[illegible] alive on 3/10 1947

Immediate cause of death	Duration
Failure - Coronary Thrombosis	
Due to Arterio Sclerosis	
Due to Chronic Interstitial Nephritis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Donald H. Mills
Address St Agnes Date signed 3/10/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G13520

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G13520

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3600 Elm ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3600 Elm ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Edith Darrall Downs

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Milton C. Downs
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10 - 1865

8. AGE: Years 81 | Months 10 | Days 29 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name John Darrall
13. Birthplace Md

MOTHER
14. Maiden Name Margaret Baldwin
15. Birthplace Md.

16 (a) Informant Mrs Eva D. Tow Drake
(b) Address 3600 Elm ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof MAY 12-47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Chas. J. Beyer Jr
(b) Address MAR 22 1947 Eutaw & Lanvale Sts Baltimore, Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 1947, at 7.40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 4 1945, to May 9 1947.
and that I last saw h[illegible] alive on May 9 1947.

Immediate cause of death	Duration
Cardiac decompensation	4 days
Due to Cardio-vascular renal disease	15 yrs.
Due to	—
Other Conditions — (Include pregnancy within 3 months of death)	
Date of operation —	
Major findings of operations —	
of autopsy —	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address 846 W 36th St. Date signed 5/10/47

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G19521

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 319 E. 23rd St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 319 E. 23rd St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bettie Monroe

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-1-1882

8. AGE: Years 64 | Months 3 | Days 9 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name Moses Tuggine

13. Birthplace Va

MOTHER 14. Maiden Name Harriet Taylor

15. Birthplace Va

16 (a) Informant Mrs Ruth Mann

(b) Address 319 E 23rd St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-12-47 (month) (day) (year)

(c) Cemetery or crematory Mt Lubutus Memorial Park

Location Md

18 (a) Funeral director Rayner Sanders

(b) Address 1412 E. Preston St

19 (a) (Date received by Registrar) MAR 12 1947 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 10 1947 at 6A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1947, to Mar 10 1947, and that I last saw h alive on 19

Immediate cause of death	Duration
Hypostatic Congestion	7
Due to Congestive Heart Failure	
Due to Essential Hypertension	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Emerson A Julian

Address 434 E. 23rd St Date signed 3-11-47

937

3523

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓95c

Registered No. C12522

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1730 W. Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HIRAM HARPS (Jonah Hobbs.)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Alice

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1892

8. AGE: Years	Months	Days	If less than one day
54	3	28	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Arthur Wright.
13. Birthplace Anny Arundal Co., Md.

MOTHER
14. Maiden Name Ida
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Ruth Turpin
(b) Address 228 N. Mount St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-12-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Schroeder St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9, 1947, at 1.15 a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Hemorrhage of brain (pons)

Due to Arteriosclerosis

Due to Hypertrophy of heart

Due to Edema of lungs

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 3-10-47

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 181

G19523

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G19523 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life 9 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4734 Park Heights Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Julia A. Hargesloop

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-28-1857

8. AGE: Years	Months	Days	If less than one day
89	11	10 12	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Home Wife
11. Industry or business

FATHER
12. Name Jacob Schmidt
13. Birthplace Maryland (Balto.)

MOTHER
14. Maiden Name -
15. Birthplace -

16 (a) Informant William C. Hargesloop
(b) Address 4734 Park Heights Ave Baltimore Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/12/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto. Md.

19 (a) MAR 12 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1947 at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-15 1947 to 3-9 1947 and that I last saw h.. alive on 3-9 1947.

Immediate cause of death	Duration
Cardiac failure	
Due to Insecurity because of fracture of fractured left hip.	
Due to	
Other Conditions Pressure sore on left leg. (Include pregnancy within 3 months of death)	

Date of operation 1-29-47
Major findings of operation: Well leg splint applied.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 27/16
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 1-15-47 at 8 P M
(c) Where did injury occur? 4734 Park Heights Ave (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home While at work? n/a (Specify type of place)
(e) Means of injury Slipped & fell to floor
23. Signature Richard Gordon Martin M. D.
Address Maryland Gen. Hosp. Date signed 3-9-47
for S. J. Davis, by Howard J. Hendrix, M. D.

G42524 BC# G52202

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1119a

G42524 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 mos 21 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1527 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Helen V. Gruber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17, 1946

8. AGE: Years | Months: 7 | Days: 21 | If less than one day: 24 hr. min.

9. Birthplace Baltimore Baltimore, Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name George Gruber
13. Birthplace Maryland

MOTHER 14. Maiden Name Beatrice O'Donnell
15. Birthplace Virginia

16 (a) Informant Beatrice Gruber
(b) Address 1527 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/12/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) Huntington Williams
(Date rec'd by registrar) MAR 12 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1947 at 1045 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 16 1947 to March 10 1947 and that I last saw h.er alive on March 10 1947

Immediate cause of death: Acetonemia — Duration

Due to: Dehydration

Due to: Diarrhea

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward A. Burkhart, M.D.
Address Md. Gen. Hosp Date signed 3/10/47

G49525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G49525 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp. 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 21 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2713 Parkwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: IDA MAE WHITE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife: Wm. R. White
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1, 1879

8. AGE: Years	Months	Days	If less than one day
67	10	9	hr. min.

9. Birthplace: Va.
(Town, county, and state)

10. Usual Occupation: -

11. Industry or business

FATHER
12. Name: Daniel Marshall
13. Birthplace: Va.

MOTHER
14. Maiden Name: Theresa Bell
15. Birthplace: Va.

16 (a) Informant: Mr. Clifton T. White
(b) Address: 2713 Parkwood Ave.

17 (a) Removall (Burial, cremation, or removal) (b) Date thereof 3.18.47 (month) (day) (year)
(c) Cemetery or crematory: Greenmount Cem.
Location: Sanford, Va.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Baltimore, Md.

19 (a) 3-18-1947 (Date received by registrar) (b) Lucretia Williams Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-10 1947 at 11.50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-10 1947 to 3-10 1947 and that I last saw her alive on 3-10 1947

Immediate cause of death: Arteriosclerotic Heart Disease — Duration

Due to: Coronary thrombosis

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Nathan B. Myerson M. D.
Address: Sinai Hospital Date signed 3-10-47

X

G49526 BALTIMORE CITY HEALTH DEPARTMENT G49526
Registered No.

CERTIFICATE OF DEATH 74a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3337 and Calvert
(c) Hospital or institution: Union Mem Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days
(e) Length of stay in Baltimore (yrs., mos., or days) 71 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2312 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME DRYDEN, HOWARD S,

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Maude E. Dryden
6 (c) If alive, give age [illegible] years

7. Birth date of deceased (mo., day, yr.) Dec 1, 1875

8. AGE: Years	Months	Days	If less than one day
71	3	9	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation Retired Buyer
11. Industry or business

FATHER
12. Name Sidney Dryden
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Waters
15. Birthplace Virginia

16 (a) Informant Mrs. Maude E. Dryden
(b) Address 2312 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/13/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date received by local registrar MAR 12 1947 (b) Harrington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 14 1947 to March 10 1947, and that I last saw him alive on March 10 1947.

Immediate cause of death: Myelogenous Leukaemia — Duration: 1 Month
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph C. Preatt M. D.
Address Union Mem Hosp Date signed March 10, 1947

C49527

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

C49527 Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore County, Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2 Kinship Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dr. Adam W. Reier

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No.: none

4. Sex: M
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Sadie E. Reier (nee Davis)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1887

8. AGE: Years 58 | Months 7 | Days | If less than one day ____ hr. ____ min.

9. Birthplace Md. (Glen Arm) (Town, county, and state)

10. Usual Occupation Physician

11. Industry or business

FATHER
12. Name Adam Reier
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Stiegler
15. Birthplace Md.

16 (a) Informant Mrs. Adam W. Reier
(b) Address 2 Kinship Rd., Dundalk, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof # 3/13/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) MAR 12 1947 Registered by (b) Clayton Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-10 1947, at 8:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-4-1947 to 3-10-1947, and that I last saw h. alive on 3-10-1947.

Immediate cause of death	Cardiac failure	Duration
Due to	Coronary Occlusion	
Due to		
Other Conditions		

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles H. Mackenzie M.D.
Address University Hospital Date signed 3-10-47

G12528

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G12528 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Frieden + Meadow Rds
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mo
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. Pimlico Rd., R. F. D. #7
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian (Lotz) May Lewis

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 216-09-1743

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 27, 1881

8. AGE: Years	Months	Days	If less than one day
65	10	14	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Floor Supervisor
11. Industry or business O'Neill's Dept. Store

FATHER
12. Name John J. Lewis
13. Birthplace Unknown

MOTHER
14. Maiden Name Harriett E. Nizer
15. Birthplace Unknown

16 (a) Informant Mrs. Harriett R. Tauber, Niece
(b) Address Pimlico Rd., Mt. Washington

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/14/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) MAR 12 1947 (Date rec'd by registrar) (b) Washington Williamsport, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1947 at 10:5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/10/1946 to 3/11/1947 and that I last saw her alive on 3/11/1947

Immediate cause of death	Duration
Cardiac failure	
Due to Coronary occlusion	
Due to Diabetes mellitus	4 mos.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C.E. Gonzalez
Address Maryland General Hosp Date signed 3/11/47

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C43529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C43529

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 17
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 506 Myrtle Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lottie Johnson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation unemployed
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Mrs. McGruder
(b) Address ?

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/12/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemet.
Location Cedar Hill Md.

18 (a) Funeral director R. Halstead
(b) Address 913 Druid Hill Ave.
MAR 12 1947 Huntington Williams, Md.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/12 1947 at 10 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ? death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V.D.
Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 3/15/47

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED

G49530

CWK-85559

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 107

Registered No. G49530

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3- 2- 19-
(e) Length of stay in Baltimore (yrs., mos., or days) 57 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1413 Webster Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ignatius Brokos

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?? 1869

8. AGE: Years	Months	Days	If less than one day
? 78	?	?	hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name ? Brokos
13. Birthplace Poland

MOTHER
14. Maiden Name ?
15. Birthplace Poland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof Mar. 13-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem.
Location Annapolis Blvd.

18 (a) Funeral director Chas. F. Dull
(b) Address 1031 E. Fort Ave.

19 (a) MAR 12 1947 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1947, at 6:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 21 1946 to March 10 1947 and that I last saw him alive on March 10 1947

Immediate cause of death	Duration
Bronchial pneumonia	3 days
Due to Generalized arteriosclerosis	10 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. D.
Address Baltimore City Hosp. Date signed 10 Mar 47

VS 150

G49531

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G49531

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1454 Decatur St.
(c) Hospital or institution: 24

(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1454 Decatur St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Robert V. Schonowski

3 (b) If veteran, name war: No.

3 (c) Social Security Account No. 215-01-9554

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Virginia

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 19, 1899

8. AGE: Years 47 | Months 7 | Days 19 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Stevedore

11. Industry or business

FATHER
12. Name Frank Schonowski
13. Birthplace Poland

MOTHER
14. Maiden Name Mathilda Zaleski
15. Birthplace Poland

16 (a) Informant Helen Kempel
(b) Address 3110 Kentucky Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-14-47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Annapolis Blvd.

18 (a) Funeral director Chas. F. Dell
(b) Address 1501 E. Fort Ave

19 (a) MAR 12 1947 (Date received by Registrar) (b) Hunting Williams (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-10 1947, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-6, 1947 to 3-10 1947 and that I last saw h.... alive on 3-10 1947

Immediate cause of death	Duration
(a) Lobar Pneumonia	2 days
Due to	
Due to	
Other Conditions Cirrhosis of Liver	2 mo.?

(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature A. Ballod M. D.
Address 707 Fort Ave. Date signed 3-12-47

for Permit

G49532

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G49532 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3707 Roland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 71 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3707 Roland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Jane Leach

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1860

8. AGE: Years 86 Months 10 Days If less than one day hr. min.

9. Birthplace Freeland Md (Town, county, and state)
10. Usual Occupation house work
11. Industry or business

FATHER
12. Name Thomas R Leach
13. Birthplace Md

MOTHER
14. Maiden Name Lena Johnson
15. Birthplace Pa

16 (a) Informant William Leach
(b) Address 3707 Roland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 13 47 (month) (day) (year)
(c) Cemetery or crematory Mt Lebanon
Location Dreland Md

18 (a) Funeral director Durand W Betz
(b) Address 814 W 36 St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 MAR 12 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1947, at 3:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 16 1947 to March 11 1947 and that I last saw h[illegible] alive on March 10 1947

Immediate cause of death Cardiac decompensation — Duration 23 days

Due to Chronic Cardio-Vascular Renal Hypertension

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 846 W 36 St Date signed 3/11/47 D.

X

C19533 CMR-109000

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 479

Registered No. C19533

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Aveme
(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1512 N. Bradford Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Earl Wilson Murray

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-18-2058

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Anne
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8-1883

8. AGE: Years	Months	Days	If less than one day
63	11	2	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Clifton Murray
13. Birthplace Maryland

MOTHER
14. Maiden Name Betty Gorsuch
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 3-14th 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Leo B. Decook
(b) Address 1701-03 N. Patterson Park Ave

19 (a) (b)
(Date rec'd by Registrar) Registrar

MAR 12 1947

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION A

20. DATE OF DEATH March 10 1947, at 10:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 9 1947 to March 10 1947, and that I last saw h. im alive on March 10 1947

Immediate cause of death: Carcinoma of Rt. Lung with extensive metastases to Brain — Duration: Unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maurice M. Lacy, M.D.
M. D.
Address Baltimore City Hosp. Date signed 3-14-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49531
CWK-82040

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G49534
Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3- 8- 26-
(e) Length of stay in Baltimore (yrs., mos., or days) 66- 8- 9-

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1924 Aliceanna Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Matthew Fox

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Seperated

6 (b) Name of husband or wife Elizabeth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1-1880

8. AGE: Years	Months	Days	If less than one day
66	8	9	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George
13. Birthplace Maryland

MOTHER
14. Maiden Name Anna Sarabeck
15. Birthplace Germany

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 3/13/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Dundalk Ave

18 (a) Funeral director Lilly & Richardson
(b) Address 4643 Eastern Ave

19 (a) MAR 12 1947 (b)
(Rec'd by registrar)

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH March 10 19 47 at 1:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 14 19 45 to March 10 47, and that I last saw him alive on March 10 19 47.

Immediate cause of death	Duration
Myocardial Insufficiency	6 mo
Due to Arteriosclerosis Generalized	20 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. R. McDonald M. D.
Address Baltimore City Hosp. Date signed 10 Mar 47

G49535

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G49535 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3919 Hudson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3919 Hudson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilhelmia Kuchenmeister

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife John
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 13, 1864

8. AGE: Years	Months	Days	If less than one day
83	1	25	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Klein
13. Birthplace Germany

MOTHER
14. Maiden Name not known
15. Birthplace Germany

16 (a) Informant Mrs. Margaret Fitzberger
(b) Address 3919 Hudson St.

17 (a) Burial (b) Date thereof 3/13/37
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) (b)
(Date rec'd by Registrar) Huntington Williams

MAR 12 1937

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1937 at 10:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 7, 1937 to March 10 1937, and that I last saw h.er alive on March 7 1937.

	Duration
Immediate cause of death Coronary Thrombosis	3 Days
Due to Arteriosclerotic Cardio Vascular Disease	7
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jason W. Gerbel M. D.
Address 636 S. Caroline St. Date signed March 11 37

X

G19536 BCH B 72029

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G19536 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 518 N. Schroeder St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 14 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 518 N. Schroeder St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Parker

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 25, 1947

8. AGE: Years	Months	Days	If less than one day
—	—	14	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Perlie Parker
13. Birthplace Clinton, N.C.

MOTHER
14. Maiden Name Mary Dorsey
15. Birthplace Baltimore, Md.

16 (a) Informant Mary Dorsey Parker
(b) Address 518 N. Schroeder St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Local Johns Hopkins Medical School MAR 12 1947

18 (a) Funeral director Commissioner of Health
(b) Address

MAR 12 1947 (Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11, 1947, at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/25 1947, to 3/11 1947, and that I last saw h[illegible] alive on 3/7 1947.

Immediate cause of death: Aspiration of vomitus — Duration: 2 days
Due to
Due to
Other Conditions Prematurity
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William L. Miller M. D.
Address Univ. Hosp. Date signed 3-11-47

X

G49537

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G49537

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balt. City.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 12 E. Read St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isabella C Murphy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Unmarried

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct 24. 1876

8. AGE: Years	Months	Days	If less than one day
70	4	17	hr. min.

9. Birthplace Scotland
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Isabel Pitchelly
(b) Address 12 E Read St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/14/47 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore Md

18 (a) Funeral director Wilson & Son
(b) Address 1217 E Fort Ave

19 (a) 3-12-1947 (Date rec'd by local registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-11- 1947, at 11:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-5- 1947 to 3-11-1947, and that I last saw her alive on 3-11- 1947

Immediate cause of death	Duration
Cardiac failure	
Due to Hypertensive Cardio-Vascular disease with decompensation	
Due to Grade III	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles H Strauss M.D.
Address University Hospital Date signed 3-12-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1310

G49538 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 132 N Linwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 132 N Linwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Arthur B Shoul

3 (b) If veteran, name war

3 (c) Social Security Account No. 195-07-0862

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Celia M

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 17 1880

8. AGE: Years 66 | Months 6 | Days 20 | If less than one day hr. min.

9. Birthplace Ellenville N Y (Town, county, and state)

10. Usual Occupation Inspector

11. Industry or business Gov't Mail Service

FATHER 12. Name Jeneyck Shoul

13. Birthplace N Y

MOTHER 14. Maiden Name Emma Dunn

15. Birthplace N Y

16 (a) Informant Celia M Shoul

(b) Address 132 N Linwood Ave

17 (a) Burial, cremation, or removal Interred (b) Date thereof 3-15-47 (month) (day) (year)

(c) Cemetery or crematory East Harrisburg

Location East Harrisburg Pa

18 (a) Funeral director Wilhelm Bros Inc

(b) Address 1317 Ft Ave

19 MAR 12 1947 Date received by registrar — Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 12 1947, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1947 to Mar 12 1947 and that I last saw h[illegible] alive on Mar 12 1947

Immediate cause of death: Cerebral Hemorrhage — Duration 1 D

Due to: Hypertension — 5 yrs.

Due to: Arteriosclerosis

Other Conditions: Heyward Cystitis. Pulmonary Edema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm G Thayer M.D.

Address 156 W Melton Ave Date signed 3/12/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR

C19539

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/31a

C49539 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3716 E. Lombard Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3716 E. Lombard Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Gephardt

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Widowed

6 (b) Name of husband or wife Kate H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 4, 1874

8. AGE: Years	Months	Days	If less than one day
73 72	1	7	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name George B. Gephardt
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret ?
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Elizabeth Wiser
(b) Address 10 S. Robinson Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/14/47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) MAR 13 1947 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-11-47 19 , at 4:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-26-46 19 , to 3-11-47 19 , and that I last saw h— alive on 3-10-47 19 .

Immediate cause of death	Duration
Arteriosclerotic Cardiovascular Disease	
Due to Hypertrophied Arteriosclerosis	
Due to	
Other Conditions Arteriosclerosis Kidney Disease (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Constantine, M.D. M. D.
Address 234 E. Conkling St Date signed 3-12-47

Huntington Williams, M.D.

927

G49540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93c

Registered No. G49540

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1407 Caehorn St.
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days) mons
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DEACEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1407 N. Caehorn St (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cora Ball

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Warner Ball
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 18-94

8. AGE: Years 53 | Months — | Days — | If less than one day hr. min. 52

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Home work
11. Industry or business own home

FATHER 12. Name Oscar Morris
13. Birthplace Va

MOTHER 14. Maiden Name Emma Tolmer
15. Birthplace Va

16 (a) Informant Susie Coffman
(b) Address 224 S. Green St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-15-47 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Md
Location

18 (a) Funeral director Geo. G. Nelson
(b) Address 1303 Pennsylvania Ave

19 (a) (Date rec'd by registrar) (b) Harlington Wills registrar

VS 150
MAR 13 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-12-1947, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-15-1947 to 3-12-1947
and that I last saw her alive on 3-11-1947

Immediate cause of death: Myocarditis — Duration: Months

Due to: Lumbago

Due to:

Other Conditions Polyarthritis — 4 years

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank H. Saunders M. D.
Address 1029 N. Stricker St Date signed 3-13-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. 3698

040541

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1123 Woodyear St.
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) none
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1123 Woodyear St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Reader Turner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: John Turner

6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) Nov 11 1879

8. AGE: Years: 67 | Months: 4 | Days: - | If less than one day: ——hr. ——min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business House work

FATHER — 12. Name John Reeder
13. Birthplace md

MOTHER — 14. Maiden Name Marian Mack
15. Birthplace Md

16 (a) Informant Mamie Spriff
(b) Address 1357 Woodyear St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-14-47 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location md

18 (a) Funeral director Geo G. Kelson
(b) Address 1303 Freestman St

19 (a) ——— (Date rec'd by registrar) (b) ——— Registrar

MAR 13 1947 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 — 11 — 1947, at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-8-1946 to 3-11-1947 and that I last saw h.er alive on 3-10-1947

	Duration
Immediate cause of death: Myocardial dis	Unknown
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank A. Saunders M. D.
Address 1029 N. Stricker St Date signed 3-13-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

~~C49518~~ 108 ~~C49518~~

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1627 W Lafayette ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1627 W. Lafayette ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank De Shields ✓

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	colored	married

6 (b) Name of husband or wife Laura De Shields
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 7, 1886

8. AGE: Years	Months	Days	If less than one day
60	4	3	hr. min.

9. Birthplace md (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business

FATHER
12. Name Joseph De Shields
13. Birthplace md

MOTHER
14. Maiden Name Mary Gray
15. Birthplace md

16 (a) Informant Laura De Shields
(b) Address 1627 W. Lafayette ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-13-47 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location md

18 (a) Funeral director George G. Nelson
(b) Address 1303 Presstman St

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1947, at 1:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 12 1947, to Mch 10 1947 and that I last saw h[im] alive on Mch 10 1947.

Immediate cause of death	Duration
(a) Metastatic pneumococcus	7
Due to	
(b)	
Due to	
(c) Lobar Pneumonia	10 days
Other conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy: Negative

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. J. Hughes M. D.
Address 1013 Dumbarton Hall Dr Date signed Mch 12

VS 150

92B/1949

C49543 BALTIMORE CITY HEALTH DEPARTMENT C49543
CERTIFICATE OF DEATH 48 B Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 113 N. Mount St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19+
(e) Length of stay in Baltimore (yrs., mos., or days) 6

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No 113 N. Mount St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Anna Parsons
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widowed
6 (b) Name of husband or wife Sydney Parsons
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 9-29-1894
8. AGE: Years 52 | Months 6 | Days 10 | If less than one day hr. min.
9. Birthplace Hertford N.C (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business —
FATHER 12. Name Henry Gregory
13. Birthplace Hertford N.C
MOTHER 14. Maiden Name Rose Anna Nixon
15. Birthplace Hertford N.C
16 (a) Informant Edna Parsons
(b) Address 113 N. Mount St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 13 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn, Location
18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.
MAR 13 1947 (b) (Date rec'd by Registrar)

MEDICAL CERTIFICATION
20. DATE OF DEATH March 10 1947 at 3 M
21. I certify that death occurred on the date above stated; that I attended deceased from 2/4 1947 to 3/10 1947.
and that I last saw h[illegible] alive on 3/9 1947.
Immediate cause of death Broncho Pneumonia — Duration
Due to Terminal Carcinoma Uteri
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature W. T. Harvey M. D.
Address 601 N. Carrollton Ave signed 3/14/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.
MARGIN RESERVED FOR BINDING

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49544 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G49544

CERTIFICATE OF DEATH ✓ 30D

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Md. General Hosp. 17-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26a
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 740 W. Franklin St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME BERTHA (BERTIE) GIBSON ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	C	

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 8, 1892

8. AGE: Years	Months	Days	If less than one day
54	8	22	.....hr. .....min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name William Tankard
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Tankard
15. Birthplace Md.

16 (a) Informant Lillian Bailey
(b) Address 740 W. Franklin

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-14-1947 (month) (day) (year)
(c) Cemetery or crematory Int. Auburn
Location.....

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) [illegible] (b).....
(Date rec'd by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-10-1947, at 7:15 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH.....
Bronchopneumonia
Syphilitic aortitis
Due to Aneurysm of aorta

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place? .....While at work?.....
(d) Means of injury.....

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 3/11/47

BALTIMORE CITY HEALTH DEPARTMENT

G49515 **CERTIFICATE OF DEATH** 94a Reg(#) G49515

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Sinai Hospital
(b) Street address Monument & Rutland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3604 Menlo Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Maurice M Dessen

3 (b) If veteran, name war: 1
3 (c) Social Security Account No. 216-10-8028

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Shirley Nee Kaplan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct, 31, 1897

8. AGE: Years	Months	Days	If less than one day
49	4	12	hr. min.

9. Birthplace Philadelphia Pa (Town, county, and state)
10. Usual Occupation
11. Industry or business Credit Manager

FATHER
12. Name Abraham Dessen
13. Birthplace Russia

MOTHER
14. Maiden Name Ada ?
15. Birthplace Russia

16 (a) Informant Mrs Shirley [illegible]
(b) Address 3604 Menlo Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 12, 1947 (month) (day) (year)
(c) Cemetery or crematory Shaarai Tfilola Cemetery
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (Date rec'd by registrar) (b) (Registrar)

MAR 13 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12, 1947, at 2:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 12 1947 to March 12 1947, and that I last saw h/im alive on March 12 19 47

Immediate cause of death: Myocardial failure — Duration:
Due to: Myocardial impairment
Due to: Coronary artery disease
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sidney Green M. D.
Address Sinai Hospital Date signed 3/12/47

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49546

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 462

G49546 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave.
(c) Hospital or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3602 Windsor Mill Road (If rural give location)
(e) Citizen of foreign country? YES (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie E. Day

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26/63

8. AGE: Years	Months	Days	If less than one day
83	7 6	15	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Home duties

11. Industry or business

FATHER
12. Name James W. Flack
13. Birthplace Balto.

MOTHER
14. Maiden Name Mary Elizabeth Flack
15. Birthplace Balto.

16 (a) Informant Naomi Crowl
(b) Address 3602 Windsor Mill Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/13/47 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location North & Greenmount Aves.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by Registrar) MAR 13 1947 (b) Hunting for Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1947, at 6 P. M

21. I certify that death occurred on the date above stated. That I attended deceased from March 11 1947 and that I last saw h[illegible] alive on March 11 1947.

Immediate cause of death: E. Laureton — Duration: 1 wk

Due to

Due to: Gastric Carcinoma — Duration: 1 wk

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 112 W. 25th St. Date signed Mar 13 47

G49547

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83B

Registered No. G49547

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR

1. PLACE OF DEATH:

(a) Baltimore City, Maryland.

(b) Street address Williams Ave

(c) Hospital or institution: St Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) 4

(d) Street No. 9 S. Fulton Ave. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs Katherine Mulcahy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widow

6 (b) Name of husband or wife John F. Mulcahy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2 27 1872

8. AGE: Years	Months	Days	If less than one day
74	2	16	hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Husband Laughs

FATHER 12. Name [redacted]

13. Birthplace Ireland

MOTHER 14. Maiden Name [redacted] and likes

15. Birthplace Ireland

16 (a) Informant John Mulcahy

(b) Address Falling Rd., Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/15/1947 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore

18 (a) Funeral director George F. Farley

(b) Address Butler Bros. & Fayette St

19 (a) (Date rec'd by registrar) 1947 (b) Registrar Huntington Holmes, M.D.

MAR 13

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/12 1947, at 12:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/8 1947, to 3/12 1947, and that I last saw her alive on 3/12 1947.

Immediate cause of death	Duration
Cardiac Failure	
Due to Pneumonia	
Due to Acute Dilatation	
Due to Cerebral Embolic	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature, M.D. [signature]

Address St. Agnes Hosp. Date signed 3/13/47

X

G49518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G49518

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 836 W Baltimore St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18-1
(e) Length of stay in Baltimore (yrs., mos., or days) Toyre

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give name)
(d) Street No. 836 W Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Tillie Diamond

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Robert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 76 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name unknown

13. Birthplace Russia

MOTHER 14. Maiden Name unknown

15. Birthplace Russia

16 (a) Informant Robert Diamond

(b) Address 836 W Balto St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-13-47 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Philadelphia Hamilton Ave

18 (a) Funeral director Jack Levin Inc

(b) Address 1132 E Balto St

19 MAR 12 1947 (Date filed by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1947, at 7:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from MAR 6 1947 to MAR 12 1947, and that I last saw her alive on MAR 11 1947.

Immediate cause of death: Cerebral Hemorrhage — Duration 6 D

Due to: Ruptured Artery

Due to: arteriosclerosis

Other Conditions: Art. Scl. Cardio-Vascular Disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature K. Krulewitz, M.D.

Address 2116 W. Pratt St. Date signed 3/13/47 M. D.

V S 150

83a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M. D. B. 1206-0

G49519 **HEALTH DEPARTMENT—CITY OF BALTIMORE** G49519

CERTIFICATE OF DEATH V1310

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 819 N. Fulton Ave St., ... Ward)

Registered No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S. If of foreign birth? ..... yrs. ..... mos. ..... ds.

2. FULL NAME Arthur B. Portillo

(a) Residence: No. 819 N Fulton Ave St., 16-3 Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
M	Colored	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Ella Portillo

6. DATE OF BIRTH (month, day, year): April 23, 1887

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
59	10	18	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: Cement finisher

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.: .....

10. Date deceased last worked at this occupation (month and year): .....

11. Total time (years) spent in this occupation: .....

12. BIRTHPLACE (city or town) (State or country): Brunswick Co Va

FATHER

13. NAME: David Portillo

14. BIRTHPLACE (city or town) (State or country): Brunswick Co Va

MOTHER

15. MAIDEN NAME: Sarah Harrison

16. BIRTHPLACE (city or town) (State or country): Brunswick Co Va

17. INFORMANT: Howard B Portillo
(Address) 819 N. Fulton Ave

18. BURIAL, CREMATION, OR REMOVAL
Place Mt Calvary Cem Date March 16, 1947

19. UNDERTAKER: Mrs Gilbert A. Elliott Dom't
(Address) 1229 N. Carlton St

20. FILED MAR 13 1947 Huntington Williams Registrar

N. B. WRITE PLAINLY, WITH UNFADING INK. AGE should be carefully supplied. Exact information should be carefully supplied. AGE should be properly classified. Exact information should be carefully supplied. AGE should be properly classified. Exact information should be carefully supplied. AGE should be properly classified

G49550

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G49550

MARGIN RESERVED — Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W. Hoffman St.
(c) Hospital or institution: Home for Incurables 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W. Hoffman St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eleanor Gittings Price

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Jr. Abraham H. Price
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13, 1857

8. AGE: Years	Months	Days	If less than one day
89	10	29	hr. min.

9. Birthplace Manor, Harford Co., Md. (Town, county, and State)
10. Usual Occupation None
11. Industry or business —

FATHER
12. Name Jr. Nicholas J. Hutchins
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Eleanor Gittings Royston
15. Birthplace Manor, Harford Co., Md.

16 (a) Informant Jane L. Adamson (Supt.)
(b) Address Home for Incurables

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-13-47 (month) (day) (year)
(c) Cemetery or cremator St. James Cem.
Location Parkton, Md.

18 (a) Funeral director Wm. J. Chisholm & Sons
(b) Address No. 1 Pa. Ave. Balto. Md.

19 (a) MAR 13 1947 (Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12, 1947, at 6 12 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/22 1940 to 3/12 1947, and that I last saw h alive on 3/11 1947.

Immediate cause of death	Duration
(a) Cerebral Hemorrhage	5 Days
Due to (b) Hypertension Cardio-Vascular Disease	10 years
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Stratton Hargrave M. D.
Address 214 Medical Arts Bldg. Date signed 3/12/47

VS 3

Huntington Williams MD

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 019551

~~019551~~ 937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland
(b) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(c) Street No. 739 Vine Street (If rural give location)
(d) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUISA BOWEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years 50 | Months | Days | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation D

11. Industry or business

FATHER 12. Name John Smith
13. Birthplace Md

MOTHER 14. Maiden Name Emma Johnson
15. Birthplace Md

16 (a) Informant Sadie Thomas
(b) Address 741 Vine St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/13/47 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary
Location A.A. Co Md

18 (a) Funeral director Daniel L Brown Son
(b) Address 1016 W Monument St

19 (a) MAR 13 1947 (Date rec'd by registrar) (b) [illegible] for William [illegible] Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/9/47 19 , at 2:40 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Ward M.D. (Medical Examiner.)
Date signed 3/10/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered. Physicians: please write the correct age is especially important.

G49552

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G49552

Every item of information should be carefully supplied. Use PLEASE WRITE PLAINLY, WITH UNFADING INK. write the causes of death clearly and legibly. correct age is especially important. Physicians please write MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 514 E 20th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 514 E 20TH ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary Agnes Phillips

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: WIDOWED

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11 77

8. AGE: Years 70 | Months - | Days - | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation School Teacher

11. Industry or business

FATHER
12. Name Isaac Phillips
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mrs Alice Corcoran
15. Birthplace Baltimore Md

16 (a) Informant Mrs Lola Tillman
(b) Address 514 E. 20th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-13-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director Wiedefeld & Son
(b) Address 401 E. 20th St

19 (a) (Signature of local registrar) (b) Lexington Building Registrar

MAR 13 1947

S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/12/1947 at 5a M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/12/1947 to 3/12/1947 and that I last saw h Y V alive on 3/12 1947

Immediate cause of death Cerebral Hemorrhage

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard J. Messing, M. D.
Address 1626 N. Carlton St Date signed 3/12/47

Howard J. Messing, M. D.

G49553

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45F

Registered No. G49553

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Lombard Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2427 Llewelyn ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Cluzliotta

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-03-5352

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Helen L. Cluzliotta
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Oct 24 1901

8. AGE: Years	Months	Days	If less than one day
45	4	19	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name Philip Cluzliotta
13. Birthplace Italy

MOTHER
14. Maiden Name Josephine Ventre
15. Birthplace Italy

16 (a) Informant wife
(b) Address same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-15-47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave
18 (a) Funeral director John F. Melly Son
(b) Address 2435 E. Oliver St
19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-12 1947 at 2:20 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-5 1947 to 3-12 1947 and that I last saw him alive on 3-12 1947.

Immediate cause of death	Duration
Respiratory Center Compression with Cessation of Function	
Due to Naso-pharyngioma & metastasis with cachexia.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature J. Bevolaccuan M. D.
Address Univ. Hosp. Date signed 3-12-47

MAR 13 1947 Huntington Williams, M.D.

X

G49554

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

G49554 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1819 Hanneman
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1819 Hanneman Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Burkhardt Rebbert

3 (b) If veteran, name war | 3 (c) Social Security Account No.

Sex Male | 5 Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Margaretha Rebbert
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Sept 13, 1896

8. AGE: Years 50 | Months 5 | Days 26 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Waiters Jeweler
11. Industry or business Waiters

FATHER
12. Name John Rebbert
13. Birthplace Balt

MOTHER
14. Maiden Name Not Known
15. Birthplace Balt

16 (a) Informant Mary Rebbert
(b) Address 1819 Hannemann Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-14-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balt

18 (a) Funeral director Hugh Gorsuch
(b) Address 900 E Lanvale St

19 (a) (Date rec'd by Registrar) (b) Registrar

MAR 13 1947 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1947, at 6:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19..., and that I last saw h... alive on ..... 19...

Immediate cause of death	Duration
(a) Cerebral Hemorrhage	6 days
Due to (b) Hypertension	
Due to (c) Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 1819 Hanneman Ave Date signed 3-13-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49555

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G49555 3698

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 803 Stricker St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 803 Stricker St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian M. Jaskins
3 (b) If veteran, name war
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	colored	married

6 (b) Name of husband or wife James Jaskins
6 (c) If alive, give age (a) years

7. Birth date of deceased (mo., day, yr.) 3-11-1892

8. AGE: Years	Months	Days	If less than one day
55	0	16	hr. min.

9. Birthplace Edenton N. C.
(Town, county, and state)
10. Usual Occupation House work
11. Industry or business Own home

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs Lorine Parson
(b) Address 803 Stricker St.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 3-16-47 (month) (day) (year)
(c) Cemetery or crematory Catalina
Location Balto. Co.

18 (a) Funeral director Isaac N. Ridder
(b) Address 436 N. Riddle St.

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 13 1947 Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-11- 1947, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-8- 1947 to 3-11- 1947 and that I last saw h[illegible] alive on 3-11- 1947

Immediate cause of death	Duration
Cerebral hemorrhage	4 days
Due to	
Due to	
Other Conditions Hypertension Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank A. Saunders M. D.
Address 1029 N. Stricker Date signed 3-11-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49556

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G49556

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Josephs Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Balto Md (If outside city or town limits, write RURAL and give town)
Street No. 1906 E. 29th St. (If rural give location)
(d) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Schachner - Wills

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Frederick

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 16-1857

8. AGE: Years 89 | Months 3 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace Germany

MOTHER 14. Maiden Name

15. Birthplace Germany

16 (a) Informant Mrs Geo Wills

(b) Address 1906 E 29th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-14-47 (Month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Balto

18 (a) Funeral director J J Herr & Son

(b) Address 300 N Kentucky Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 13 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/12/47 19..., at 1 25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/6 19 47 to 3/12 19 47 and that I last saw h[illegible] alive on 3/12 19 47.

Immediate cause of death: Cardiac Pulmonary Failure — Duration

Due to Arteriosclerotic Hypertension

Due to Cardiac Vas. Disease.

Fracture of left femur (Path.)

Other Conditions Emaciation - Debilitation

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 3/6/47 at 10 45 A M
(c) Where did injury occur? Baltimore (City or town) Md (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (room) While at work? No 9:15 am
(Specify type of place)
(e) Means of injury Slipped & Fell on floor, in own room

23. Signature John B. Wills M.D.
Address St Josephs Hosp Date signed 3-12-47 M. D.
For G Wills Hospital, by Howard J. Wilson, M.D.

JL C49557 C49557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C49557

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 869 W. Franklin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Silas Carver

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years 53 ? | Months ? | Days ? | If less than one day hr. min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation Shipper

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-13-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto, Md.

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna. Ave

19 (c) MAR 12 1947 (Date rec'd by Registrar) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 19 47, at 4.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 4 19 47 to March 9 19 47, and that I last saw h in alive on March 9 19 47

Immediate cause of death Missing — Duration 2 Wks.

Due to — over

Due to

Other Conditions Cerebral Hemorrhage — 8 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Hunt
Address Balt. City Hospitals Date signed 3-11-47 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49558

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

G49558
Registered No.

MARGIN RESERVED FOR ... PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2818 Walbrook Ave.
(c) Hospital or institution: 15-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2818 Walbrook Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA EVERSMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife John H. Eversman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 4, 1862

8. AGE: Years	Months	Days	If less than one day
84	5	7	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation -
11. Industry or business

FATHER
12. Name Conrad Presson
13. Birthplace -

MOTHER
14. Maiden Name Louise Sturhlo
15. Birthplace --

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof 3/13/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.
19 (a) (Date received by registrar) (b) Registrar

MAR 13 1947 Arlington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11, 1947, 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 24 1946, to March 11 1947, and that I last saw her alive on March 9 1947.

Immediate cause of death	Duration
Arteriosclerotic heart disease	10 yrs
Due to Arteriosclerosis of the coronary arteries	
Due to	
Other Conditions Cerebral arteriosclerosis	10 yrs

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert H. Gundersheimer, M. D.
Address Riviera Apts Lake Drive Date signed Mar. 12 1947

X

G49559

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 113

Registered No. G49559

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution: University Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3831 Beach Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ira F. Belt.

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna M. Belt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8, 1889

8. AGE: Years: 57 yrs. | Months: 11 | Days: 4 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Laundry

11. Industry or business

FATHER
12. Name: Eli M. Belt
13. Birthplace: Baltimore

MOTHER
14. Maiden Name: Rachel Jane Cross
15. Birthplace: Baltimore

16 (a) Informant: Mrs. Anna M. Belt
(b) Address: 3831 Beach Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 3/15/47 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Baltimore, Md.

19 (a) [illegible] to Williams, M.D. (Date rec'd by Registrar) Registrar

MAR 18

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3/12/47 1947, at 4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/4/47 1947, to 3/12/ 1947 and that I last saw h/ alive on 3/12/ 1947.

	Duration
Immediate cause of death: Respiratory Failure	
Due to: Pulmonary T.B.	
Due to: Bronchogenic Spread	
Other Conditions: Bronchiectasis	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Dr. Leo Stolnitz M.D.

Address: University Hosp. Date signed 3/12/47

G49560

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G49560 Registered No. 94a

MARGINS RESERVED FOR BINDING. Every item of information should be carefully supplied. The PLEASE WRITE PLAINLY, WITH UNFADING INK. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 502 McCabe Ave.
(c) Hospital or institution: 27-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 502 McCabe Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** HARRY JOHN McINNES

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna E. McInnes (nee Martens)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 3, 1879

8. AGE: Years 67 | Months 11 | Days 8 | If less than one day hr. min.

9. Birthplace: New York (Town, county, and state)
10. Usual Occupation: Laundry
11. Industry or business: Self

FATHER
12. Name: John McInnes
13. Birthplace: England

MOTHER
14. Maiden Name: Lena Reith
15. Birthplace: Germany

16 (a) Informant: Mr. Donald A. McInnes, son
(b) Address: 311 Taplow Road

17 (a) Entombment (Burial, cremation, or removal) (b) Date thereof 3/14/47 (month) (day) (year)
(c) Cemetery or crematory: Greenmount Mausoleum
Location: Baltimore, Md.

18 (a) Funeral director: Wm J Jenkins & Sons
(b) Address: Balt md.
(c) MAR 13 1947 Huntington Williams, Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11, 1947, at 5A M

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 25 1947, to Mar. 11 1947, and that I last saw him alive on MAR. 11 1947.

Immediate cause of death	Duration
CORONARY THROMBOSIS	
Due to	
Due to	
Other Conditions ARTERIOSCLEROSIS	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Laurence C. Pack M.D. M. D.
Address 6805 York Road Date signed 3/12/47

X

MARGINS RESERVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49564
510875

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G49561
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Washington
(c) City or town Hagerstown (If outside city or town limits, write RURAL and give town)
(d) Street No. 1203 Virginia Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lawrence W. Bender

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-09-8222

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary L.
6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) 10-9-07

8. AGE: Years	Months	Days	If less than one day
39	5	27	hr. min.

9. Birthplace Lambertsburg Pa (Town, county, and state)
10. Usual Occupation Office Manager
11. Industry or business Home of Maids

FATHER
12. Name John K. Bender
13. Birthplace Pa

MOTHER
14. Maiden Name Lula Lemaster
15. Birthplace Pa

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 10 1947 (month) (day) (year)
(c) Cemetery or crematory Rest Haven
Location Hagerstown Md
18 (a) Funeral director Groh & Minnick Inc
(b) Address Hagerstown Md
19 (a) Mar 8 1947 (b) (Date received by Registrar) Registrar

MAR 10 1947 vs 180 Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 6th 1947, at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 1 1947 to Mar 6 1947 and that I last saw he alive on Mar. 6 1947.

Immediate cause of death	Duration
Acute Respiratory Failure	
Due to Hypertensive Cardio-vascular Renal Disease	
Due to	
Other Conditions Myelomalacia, Cause undetermined (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: (above)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature A. M. Knight, Jr. M. D.
Address Date signed

X

G49562

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G49562 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1 Caroline St
(c) Hospital or institution: St Joseph Hos.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Dundalk (If outside city or town limits, write RURAL and give name)
(d) Street No. 33 Portsluf Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Ackerman

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-09-3127

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary E.

6 (c) If ..., give age years

7. Birth date of deceased (mo., day, yr.) July 1- 1890

8. AGE: Years 56 | Months 9 | Days 11 | If less than one day: hr. min.

9. Birthplace Newburg West. Va. (Town or county and state)

10. Usual Occupation Shellfisher

11. Industry or business Both Shell Co

FATHER 12. Name Andy Ackerman

13. Birthplace France

MOTHER 14. Maiden Name Bridget Finke

15. Birthplace France

16 (a) Informant Mary E. Ackerman

(b) Address 33 Portsluf Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/47 (month) (day) (year)

(c) Cemetery or crematory Mt Carmel

Location Gilbertsville West. Va.

18 (a) Funeral director Lyn A. Wydon

(b) Address 360 E. Balto St.

19 (a) (Date rec'd by registrar) (b) Huntington Registrar

MAR 13 1947

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-12 1947, at 1 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-4 1945 to 3-12 1947, and that I last saw him alive on 3-12 1947.

Immediate cause of death: Cardiac dilatation — Duration: —

Due to: Hypertension Cardio vascular disease — Duration: 2 years

Due to: pulmonary edema — Duration: 2 days.

Other Conditions: Obstructive lesion of the pylorus (X-ray confirmed)
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene F Neary M. D.

Address 7001 Washington Blvd Date signed 3-12-47

Dundalk, Md.

G49563

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G49563

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 807 S Greene St
(c) Hospital or institution: D. of H.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 807 S Greene St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME George Hunt

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace Richmond Va. (Town, county, and state)
10. Usual Occupation Labor
11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Della Brown
(b) Address 528 W. Lee St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 8 14 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemtery
Location Baltimore, Md.
18 (a) Funeral director Walter B. Sprenkle
(b) Address 169 W. Franklin St Baltimore
19 (a) MAR 13 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/8 1947, at 7:20 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic CV disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl Lubnitz M.D. Medical Examiner.
Date signed 3/9/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G49564

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G49564
Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2006 N. Bentalou St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-4
(e) Length of stay in Baltimore (yrs., mos., or days) 41 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2006 N. Bentalou St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Katzen

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Rebecca —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1862
8. AGE: Years 85 Months Days If less than one day hr. min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Samuel Katzen
13. Birthplace Russia

MOTHER
14. Maiden Name Celia —
15. Birthplace Russia

16 (a) Informant Mrs. M. Rothman
(b) Address 1917 Cypress Falls Pkway
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-14-47 (month) (day) (year)
(c) Cemetery or crematory Hebrew Nat. Cemet
Location Fenway Nine Rd.
18 (a) Funeral director Jos Lewis Inc
(b) Address 1439 E. Balto. St
19 (a) (b)
(Date received by registrar) Registrar
MAR 13 1947
Vs 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1947 at 10:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 6, 1947 to March 13 1947, and that I last saw him alive on March 13, 1947.

Immediate cause of death Asphyxia

Due to Hypertension

Due to

Other Conditions Uremia

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis R. Mason M.D.
Address 437 N. Park Hyghts Ave Date signed 3/13/47

G49565

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G49565
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street city
(c) Hospital or institution: Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs 10 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 77 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Sarah Hawkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widow

6 (b) Name of husband of wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 13, 1869

8. AGE: Years	Months	Days	If less than one day
77	4	28	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business

FATHER
12. Name James Gaiden
13. Birthplace Ireland

MOTHER
14. Maiden Name Annie M. Brusberg
15. Birthplace Baltimore Md

16 (a) Informant Sisters of the Poor
(b) Address 1200 Valley St city

17 (a) Burial (b) Date thereof Mar. 14, 1937
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 East Biddle St
Huntington Williams, M.D.

19 (a) (b)
(Address by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mch 11 1937, at 7.00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1937, to Mch 11 1937, and that I last saw her alive on Mch 10 1937

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Chronic myocarditis	2 yrs
Due to	
Other Conditions Arterio Sclerosis	5 yrs

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E. North Ave Date signed 3/12/37

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 3

X

G49566

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

G49566
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6 E
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dda
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1732 E. Balto. St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARK SIMPSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Married

6 (b) Name of husband or wife Jane [illegible]

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years	Months	Days	If less than one day
42			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace ?

MOTHER
14. Maiden Name Unknown
15. Birthplace ?

16 (a) Informant Jane [illegible] (wife)
(b) Address 3051 Quesada St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 3/14/47 (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Washington Blvd

18 (a) Funeral director Leidy & Zeiler Inc.
(b) Address 402 N. Eutaw St

19 (a) MAR 13 1947 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1947, at 4:05 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Extensive first-, second-, and third-degree burns, covering the entire surface of the body.

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-12-47 at 9 A.M.
(b) Where did injury occur? 1732 E Balto. St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Bed caught fire

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 3/12/47

VS 191

G49567

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 111 B

Registered No. G49567

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address #3403 Toone St.
(c) Hospital or institution: 26-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3403 Toone St (If rural give location)
(e) Citizen of foreign country? Life. (Yes or No)
If yes, name country

3 (a) FULL NAME James L. Birch.

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Jane M. Birch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 18th. 1873

8. AGE: Years	Months	Days	If less than one day
73 74	5	24	hr. min.

9. Birthplace: Baltimore (Town, county, and state)
10. Usual Occupation: Cosdotian
11. Industry or business: Resgertor of Wills

FATHER
12. Name: James Birch.
13. Birthplace: Baltimore Md

MOTHER
14. Maiden Name: Ellen Fowler.
15. Birthplace: Baltimore Md

16 (a) Informant: Mrs. Jennie Birch
(b) Address: 3403 Toone St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 15th. (month) (day) (year)
(c) Cemetery or crematory: New Catherdral
Location: Old Frederick Rd.

18 (a) Funeral director: Geo. M. Fink & Son.
(b) Address: 811 N. Wolfe St.

19 (a) (Date rec'd by registrar) (b) Washington Wilkins M.D.

V. S. 160 MAR 13 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 12th 1947, 19..., at 4. A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/6 1947 to 3/12 1947, and that I last saw h[illegible] alive on 3/12 1947

Immediate cause of death: Acute Pulmonary Oedema — Duration 36 hrs.
Due to: Hypostatic Pneumonia
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:
23. Signature: [illegible] E. Balto St
Address: Date signed 3/18/47

X

G49568 BALTIMORE CITY HEALTH DEPARTMENT ✓ G49568
CERTIFICATE OF DEATH 117B Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 4-
(d) Length of stay in hospital or inst. (yrs., mos., or days) Daa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 232 Harrison Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Agnes Frye

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/6/1905

8. AGE: Years 42 | Months 1 | Days 4 | If less than one day hr. min.

9. Birthplace Roshie Pa. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant James Buster
(b) Address 232 Harrison St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/13/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy D Wilson
(b) Address 6000 Baltimore Ave

MAR 13 1947 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1947, at 12 M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to last death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Acute peritonitis due to ruptured duodenal ulcer.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Ryan M.D. Medical Examiner.
Date signed 3-11-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 191

G49569 B# B-62488

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G49569 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1015 N. 38th Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1015 N. 38th Strat (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Linda Lee Hood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 19-1946

8. AGE: Years | Months 3 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Jacob Charles Hood
13. Birthplace Maryland

MOTHER 14. Maiden Name Marion Frances Keys
15. Birthplace Maryland

16 (a) Informant Jacob B. Hood
(b) Address 1015 N. 38th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 14-1947 (month) (day) (year)
(c) Cemetery or crematory Poplar
Location Harvey, Baltimore Co. Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 MAR 13 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11- 1947, at 1.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1 1947 to 3/11 1947, and that I last saw her alive on 3-11-47 1947.

Immediate cause of death Lobar pneumonia — Duration

Due to Staphylococcus septicemia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. R. Yard M. D.
Address 123 E. Mount St. Date signed 3-12-47

MARGIN RESERVED FOR [illegible]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G49570

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1240

Registered No. G49570

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 713 N. Glover Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Charles H. Schaefer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of ~~husband~~ or wife Elizabeth M. Vomastek
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25, 1887

8. AGE: Years	Months	Days	If less than one day
60	1	17	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business American Brewery

FATHER
12. Name Henry J. Schaefer
13. Birthplace Germany

MOTHER
14. Maiden Name Agatha Nau
15. Birthplace Germany

16 (a) Informant Henry J. Schaefer - son
(b) Address 713 N. Glover Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/14/47 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Road. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) (Date rec'd by registrar) (b)

MAR 13 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 Mar 1947, at 6.20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 14 Feb 1947 to 11 Mar 1947 and that I last saw him alive on 11 Mar 1947

Immediate cause of death	Duration
Peritonitis	
Due to Post-operative	
Due to	
Other Conditions Cirrhosis of liver	

(Include pregnancy within 3 months of death)
Date of operation 3 Mar 47
Major findings of operation: Cirrhosis of liver
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard W. Penn M. D.
Address Date signed

G19571 BC# G60174 BALTIMORE CITY HEALTH DEPARTMENT ✓ G19571 Registered No.
CERTIFICATE OF DEATH 33B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 18
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1133 W. Saratoga St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willie Satterfield ✓

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-25-46

8. AGE: Years | Months: 4 | Days: 18 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Willie Satterfield
13. Birthplace D.C.

MOTHER 14. Maiden Name Janice Woodley
15. Birthplace Va.

16 (a) Informant Reeder
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-15-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) 3-13-1947 (b) Washington Williams, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/12/47 1947, at 3:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/11 1947, to 3/12 1947, and that I last saw him alive on 3/12 1947

Immediate cause of death	Duration
respiratory arrest	
Due to H. influenza meningitis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Hampson M. D.
Address J. Hopkins Hosp. Date signed 3/12/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G49572 G49572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St
(c) Hospital or institution: Union Mem Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Balto City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2730 N Charles St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HALLIDAY SOPHY S. (SOPHY SADTLER HALLIDAY)

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife John D. Halliday
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 20, 1872

8. AGE: Years 74 | Months 8 | Days 13 15 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name George Sadtler
13. Birthplace Maryland.

MOTHER 14. Maiden Name Anna Sophia Plitt
15. Birthplace Pennsylvania

16 (a) Informant Mrs. E. C. Wilson (daughter)
(b) Address Darlington Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-15-47 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore

18 (a) Funeral director Stewart Memorial
(b) Address 1810 York Ave

19 MAR 1947 (Date rec'd by registrar) Thurston Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1947, at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1947 to March 13 1947, and that I last saw h. alive on March 13 1947.

Immediate cause of death: Coronary thrombosis — During 2 weeks

Due to Hypertension - arteriosclerosis Heart decomp

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph C. Presto, M.D.
Address Union Mem Hosp Date signed 13 March 1947

VS 150

G49573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G49573 Registered No. 82

CWK-109089

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitlas 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 14 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2800 N. Calvert Street (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Proctor W. Hansel (HANSL)

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: M. Spaulding Hansl
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23-1882 (1881)

8. AGE: Years 65 | Months 8 | Days 20 | If less than one day ..... hr. ..... min.

9. Birthplace Texas (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Arthur Hansel
13. Birthplace ? VIENNA-Austria

MOTHER
14. Maiden Name Anna ?
15. Birthplace Texas

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-15-47 (month) (day) (year)
(c) Cemetery or crematory Kensico
Location Mt. Kisco - N.Y.

18 (a) Funeral director Stewart & Mower Co.
(b) Address 108 W. North Ave. - City

19 (a) MAR 13 1947 (Date filed by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH March 13 19 47, at 8:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 12 19 47, to March 13 19 47, and that I last saw him alive on March 13 19 47.

	Duration
Immediate cause of death: Respiratory Failure	
Due to: Labar Pneumonia	
Due to	
Other Conditions: Amyotrophic Lateral Sclerosis (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: None None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. R. Dearborough M. D.
Address Balto. City Hosp. Date signed 3-15-47

108

MARCH REGISTRATION. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49574 ✓ G49574

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5003 Falls Rd. Terrace
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5003 Falls Rd Terrace (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Peter Bryson Wood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Julia Carter Wood

6 (c) If alive, give age – years

7. Birth date of deceased (mo., day, yr.) Feb 8 1892

8. AGE: Years 55 | Months 1 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation (insurance)

11. Industry or business

FATHER 12. Name Peter B Wood

13. Birthplace

MOTHER 14. Maiden Name Nannie Cook

15. Birthplace

16 (a) Informant Malbon Wood (son)

(b) Address 5003 Falls Rd. Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-14-47 (month) (day) (year)

(c) Cemetery or crematory (private) Location near Middleburg-Va.

18 (a) Funeral director Stewart & Mann Co.

(b) Address 108 W. North Ave.

19 (a) (b)

(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR 12 1947 at 5 12 AM

21. I certify that death occurred on the date above stated; that I attended deceased from MAY 1946 to MAR 12 1947 and that I last saw him alive on MAR 12 1947.

Immediate cause of death	Duration
CORONARY THROMBOSIS	2 HRS
Due to ARTERIOSCLEROSIS	?
Due to HYPEIRTENSION	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ralph G. Kelly M. D. 1947

Address 18 E Eager St Date signed MAR 12

MAR 14

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CWK-10130 C10575

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. C39575

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 9- 7
(e) Length of stay in Baltimore (yrs., mos., or days) 77- 8- 28-

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4904 Woodside Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Caroline Susan Wurtzer

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13-1869

8. AGE: Years	Months	Days	If less than one day
77	8	28	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Antone (D)
13. Birthplace Switzerland

MOTHER
14. Maiden Name Louisa (D)
15. Birthplace Switzerland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/14/47. (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4301 Old Frederick Rd
18 (a) Funeral director Harry H. Wirtz
(b) Address 4101 Edmondson Ave
19 (a) (Date rec'd by registrar) (b) Huntington Wilson Registrar

MAR 13 1947

MEDICAL CERTIFICATION P

20. DATE OF DEATH March 11 1947 at 2:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 2 1947, to Mch. 11 1947, and that I last saw h er alive on Mch. 11 1947.

Immediate cause of death Bronchopneumonia — Duration 27 hrs

Due to Hypostatic pneumonia, cardio-vascular disease — 3 yrs

Due to

Other Conditions Fracture, neck, femur, R — 39 days
(Include pregnancy within 3 months of death)

Date of operation 0

Major findings of operation:

of autopsy: 0

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 28/4
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 2/2/47 at about 3 P.M.
(c) Where did injury occur? [illegible] (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Slipped on kitchen floor

23. Signature [illegible] M. D.
Address Balto. City Hosps. Date signed 3-12-47

For S. C. J. Sutowski by Howard D. Mettler, M. D.

G19576

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G19576 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 606 Somerset Rd
(c) Hospital or institution: Roland Park
77
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
14
(d) Street No. 606 Somerset Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thone Stanley Kirkwood

3 (b) If veteran, name war: Mexican Border Service
3 (c) Social Security Account

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Gelert Jacobs
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) April 1880

8. AGE: Years 66 | Months 11 | Days 11 | If less than one day: hr. min.

9. Birthplace Harford Co Md
(Town, county, and state)

10. Usual Occupation Real Estate

11. Industry or business

FATHER
12. Name Isaac Kirkwood
13. Birthplace Harford Co Md

MOTHER
14. Maiden name Caroline Bradenbaugh
15. Birthplace Harford Co Md

16 (a) Informant Mrs. Gelert Jacobs Kirkwood
(b) Address 606 Somerset Rd

17 (a) Burial (b) Date thereof Mar 12 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Henry W. Jenkins Sons Co
(b) Address McCulloh & Orchard Sts

19 (a) (Date rec'd by registrar) (b) Huntington Williams, Registrar

MAR 13 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 12 1947 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1943 to 3/12 1947.
and that I last saw him alive on 3/12 1947

Immediate cause of death: Myocarditis
Myocarditis Chronic

	Duration
Due to	1 yr
	3 4 mo
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W H Steady M. D.
Address 140 E Lexington St Date signed 3/13/47

X

G43577

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G43577 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Crawford & Retreat
(c) Hospital or institution: Jamieson St 12

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2wks
(e) Length of stay in Baltimore (yrs., mos., or days) 55yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 232 Gettier Ave W.
(If apartment or house, give No.)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katie Apple

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Sol Apple
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 26 1873

8. AGE: Years 73 | Months 11 | Days 15 | If less than one day: hr. min.

9. Birthplace Czechs Slovakia
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Leopold Stemler
13. Birthplace Czecho Slovakia

MOTHER
14. Maiden Name Sarah Fleisher
15. Birthplace Czecho Slovakia

16 (a) Informant August J. Stemler
(b) Address 1137 Maryland Ave

17 (a) Burial (b) Date thereof March 14 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem
Location Baltimore, Md.

18 (a) Funeral director Geo. A. Lee
(b) Address 1438 Eastern Ave.

(a) Filed by (Signature of registrar) (b) Date received MAR 14 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1947, at 8:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1 1946 to March 13 1947, and that I last saw h[illegible] alive on 3/12/47 1947.

	Duration
Immediate cause of death: Cardiac failure	
Due to: Cerebral arteriosclerosis	
Due to: Senile arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(d) Means of injury

23. Signature W. Reindle M. D.
Address 2314-20 N. Howard St. Date signed 3/13/47

X

MARGIN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19578

19578

BALTIMORE CITY HEALTH DEPARTMENT

Registered No. B# B 69301

CERTIFICATE OF DEATH 119a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lazaret Oakland
(c) Hospital or institution Nat'l Quar. Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 806 W. Lombard St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Charlene Mitchell

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 31 1947
8. AGE: Years | Months 1? | Days 2 weeks | If less than one day hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles Mitchell
13. Birthplace Baltimore

MOTHER
14. Maiden Name Bessie Schwartz
15. Birthplace

16 (a) Informant Charles Mitchell
(b) Address Baltimore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-15-47 (month) (day) (year)
(c) Cemetery or crematory Stone Chapel
Location Pikesville Md

18 (a) Funeral director Joseph Saunders
(b) Address 602 Washington Blvd

MAR (a) 14 1947 Registrar for Williams MD
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 March 1947 at 2:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 31 Jan. 1947 to 13 Mar 1947 and that I last saw h[illegible] alive on 13 Mar 1947

Immediate cause of death Cardio Resp. Failure — Duration

Due to Cer. Collapse

Due to Diarrhea - etc. under 1.

Other Conditions Mesenteric Lymphadenopathy

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Esther A. Stalls M. D.
Address Nat'l Quar Gen Hosp Date signed 3/13/47

PHYSICIAN — Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

579

50178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

✓ G19579 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County.....
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 17 So. KRESSION ST (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME BETTY ROSE SHEARS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	SINGLE

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1926

8. AGE: Years	Months	Days	If less than one day
20	3	21	hr. min.

9. Birthplace W. Va. (Town, county, and state)
10. Usual Occupation CLERICAL WORK
11. Industry or business

FATHER
12. Name OLIVER IRA SHEARS
13. Birthplace W. Va.

MOTHER
14. Maiden Name Dollie Powell
15. Birthplace W. Va.

16 (a) Informant RECORDS
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof March 14 1947 (month) (day) (year)
(c) Cemetery or crematory Morgantown
Location W. Va.

18 (a) Funeral director Wm. Cook Fls
(b) Address 1217 St Paul St Baltimore

19 (a) APR 1 1947 (Date rec'd by registrar) Waiting for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1947, at 12:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 20 1946, to March 13 1947, and that I last saw her alive on 13 March 47

Immediate cause of death	Duration
(a) Acute myeloid (? monocytic) leukemia	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....
23. Signature Robert C. Austin
Address John Hopkins Hosp. Date signed 13 Mar 47 M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

19580

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

74a

Registered No. C39580

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2201 W. Saratoga st.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2201 W. Saratoga St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Metcalf

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife George W. Metcalf
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 19 1863

8. AGE: Years	Months	Days	If less than one day
83	10	22	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business —

FATHER
12. Name Louis Cook
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Hamilton
15. Birthplace Ireland

16 (a) Informant Kenneth Wingate
(b) Address 2201 W. Saratoga St.

17 (a) Burial (b) Date thereof 3/14/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location Glenburnie A. A. Co. Md

18 (a) Funeral director William Cook Jns
(b) Address 1217 St. Paul St.

19 (a) MAR 14 1947 Huntington Williams M.D.
(Date rec'd by registrar) (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 11 1947, at 11 30 P.M

21. I certify that death occurred on the date above stated, that I attended deceased from 2/1 1947 to 3/11 1947
and that I last saw h. alive on 3/11 1947

Immediate cause of death

	Duration
Lymphatic Leukemia	6 mos.
Due to Lymphatic Adenitis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas A Cahn M.D.
Address 2145 W Balto Date signed 3-11-47

G49581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G49581 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2207 Bryant Ave
(c) Hospital or institution: 13-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2207 Bryant Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Moss

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Late David E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
72			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business House Work

FATHER
12. Name Meyer Land
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah Katz
15. Birthplace Russia

16 (a) Informant Albert Moss
(b) Address 2207 Bryant Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 14, 1947 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Philadelphia Road & Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

MAR 14 1947 Washington Williams, M.D.
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION 7.10

20. DATE OF DEATH March 13 1947, at P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1 1947 to 3/13 1947 and that I last saw her alive on 3/13 1947.

	Duration
Immediate cause of death Cerebral Thrombosis	3 weeks
Due to Uterine-Adnexal Cancer - Secondary Disease	2
Due to	
Other Conditions Diabetes, Nephritis (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
1947
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place While at work? (Specify type of place)
(e) Means of injury

23. Signature Jos. L. Blum M.D.
Address 1206 E Preston St Date signed 3/13/47
937

G19582

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G19582 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3912 Garrison Blvd
(c) Hospital or institution: 15 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3912 Garrison Blvd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rachel E Becker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: David

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years 81 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business House Work

FATHER
12. Name Louis Adler
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah ?
15. Birthplace Russia

16 (a) Informant Mr David Becker
(b) Address 3912 Garrison Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 14, 1947 (month) (day) (year)
(c) Cemetery or crematory Bnai Israel Cemetery
Location Southern Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13, 1947, at 3.30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 10, 1947. to March 13 1947. and that I last saw her alive on March 13, 1947.

Immediate cause of death Coronary Insufficiency. Myocardial Failure. — Duration: about 15 yrs. duration

Due to Hypertension.

Due to Diabetes

Other Conditions (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nathan H Shnitzer M.D.
Address 1810 Eutaw Place Date signed 3/17/47.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G49583

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G49583 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Morris
(b) Street address 923 Hanover
(c) Hospital or institution: Univ 11-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 923 Hanover
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Estella Jones Allen ALLEIN ✓

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Clifton Allen
6 (c) If alive, Deceased years

7. Birth date of deceased (mo., day, yr.) 12/16/1882

8. AGE: Years	Months	Days	If less than one day
64	4	28	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business None

FATHER
12. Name Unknown
13. Birthplace Md

MOTHER
14. Maiden Name Susan Jones
15. Birthplace Balto Md

16 (a) Informant Edna Allen
(b) Address 923 Hanover

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-17-47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem.
Location Maryland

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VR MAR 14 1947 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/13/47 19 DA M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/14/47 19 to 3/13/47
and that I last saw h alive on 3/11/47

Immediate cause of death Bronchopneumonia — Duration 7 days
Due to Bronchopneumonia
Due to Fell and fractured Neck of Femur
Followed chronic
Other Conditions general arthritis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature A. Ewing Elliott M. D.
Address 924 Hanover Date signed 3/14/47

X

C49584

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

Registered No. C49584

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver Sts
(c) Hospital or institution St Josephs Hospital
(d) Length of stay in hospital or inst. (years, mos., or days) 1½ Hours
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A.A.
(c) City or town Pasadina, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Lake Shore
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Elsie M. Monson

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Charles E. Monson
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) June 25, 1907

8. AGE: Years	Months	Days	If less than one day
39.	8	15 17	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Agustus Schroeder
13. Birthplace Germany

MOTHER
14. Maiden Name Anna M. Shipley
15. Birthplace Baltimore, Md.

16 (a) Informant Chas. E. Monson
(b) Address Lake Shore, Pasadina, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/15/47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A.A. County

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

19 (a) MAR 14 1947 (Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1947, at 4.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from MAR 12 1947 to MAR 12 1947 and that I last saw her alive on MAR 12 1947

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Cardiac Decompensation	
Due to Aortic Stenosis Aortic insufficiency	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation
of autopsy: Aortic Stenosis and insufficiency

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John B Wells M.D.
Address St Josephs Hosp Date signed 3-14-47 M.D.

G49585

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G49585 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Evansprings Ave
(c) Hospital or institution: Levendale
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3813 Cataway Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Fzodick Shulman

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed or divorced: Widowed
6 (b) Name of husband or wife: Leare
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1860
8. AGE: Years 87 | Months | Days | If less than one day hr. min.
9. Birthplace: Russia (Town, county, and state)
10. Usual Occupation: Retired
11. Industry or business:

FATHER
12. Name: Hyman
13. Birthplace: Russia

MOTHER
14. Maiden Name: Bosha
15. Birthplace: Russia

16 (a) Informant: Mrs Lavinne Schwartz
(b) Address: 3813 Calaway ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-14-47 (month) (day) (year)
(c) Cemetery or crematory: Rosedale
Location: Philadelphia & Hamilton Ave
18 (a) Funeral director: Jack Levey Inc
(b) Address: 1619 E Balto St
19 (a) (Date rec'd by registrar) (b) Registrar

VS MAR 14 1947 Huntington Hillsdale, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1947, at 3.30 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 3-2 1947 to 3-13 1947, and that I last saw h[illegible] alive on 3-13 1947.

Immediate cause of death	Duration
Ch. card. vascular disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. Edmund Levey
Address Levendale Date signed 3/13/47

X

G49586

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G49586

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 N. Castle St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 weeks

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1016 S. Decker ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME Martha J. Adamski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Michael

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years About 70 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Skalski
13. Birthplace Poland

MOTHER
14. Maiden Name —
15. Birthplace Poland.

16 (a) Informant Michael Adamski
(b) Address 1016 S. Decker ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/47 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location City

18 (a) Funeral director Wm. J. Fialkowski
(b) Address 2007 Eastern Ave

19 MAR 14 1947 (Date rec'd by registrar) Thomas Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1947, at 10 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Novemb. 1944 to March 13 1947. and that I last saw her alive on March 12 1947.

Immediate cause of death
Chr. Myocarditis
Chr. Nephritis
Due to Chr. Hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operations
of autopsy None

Duration
3 years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. A. Rosenblatt M. D.
Address 3018 O'Donnell St Date signed 3-13-47
Baltimore, 24, Md

VS 150

G49587

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G49587

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2222 McElderry St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2222 McElderry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Frederick Fischer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Marie Fischer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15-1888

8. AGE: Years 58 | Months 9 | Days 28 | If less than one day ____ hr. ____ min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Balto. City

FATHER 12. Name Fischer

13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Not Known

15. Birthplace Not Known

16 (a) Informant Marie Fischer

(b) Address 2222 McElderry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 16-47 (month) (day) (year)

(c) Cemetery or crematory Loudon Pk. Cem.

Location Frederick Rd.

18 (a) Funeral director John F. Miller

(b) Address 2334 Jefferson St.

MAR 14 1947 (Date filed with Registrar) Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 13- 1947, at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1946 to Mar 13 1947. and that I last saw h[e] alive on Mar 12 1947

Immediate cause of death Carcinoma of Sigmoid — Duration 1943

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1945

Major findings of operation: Ca. of Sigmoid

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. J. Boehmer

Address 3426 Bank St Date signed Mar 13/47

3588 BC# 493182 - G46680

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1579

✓ G49588 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway and Monument Sts.
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 916 W. Barre St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Kenneth H. Kummer, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-30-46

8. AGE: Years	Months	Days	If less than one day
	10	13	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Kenneth H Kummer, Sr.
13. Birthplace Baltimore md.

MOTHER
14. Maiden Name Emma McLemore.
15. Birthplace Huntingdon Wr. Va

16 (a) Informant Mr. Kenneth H. Kummer
(b) Address 916 W. Barre St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 15, 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director Miles L. Donovan
(b) Address 4240 Liberty Heights Ave.

19 (a) MAR 9 A 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH March - 13 1947 at 4.23 M

21. I certify that death occurred on the date above stated; that I attended deceased from May - 7 1946, to March - 13 1947, and that I last saw him alive on March - 13 1947

Immediate cause of death	Duration
? Intracranial hemorrhage ?? thrombosis, ?? embolism	
Due to Esophageal stricture - tracheo - esophageal fistula and	
Due to atelectasis RUL	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert Fruchtbaum M. D.
Address Johns Hopkins Hosp. Date signed 3-13-47

X

M. D. B. 1968-6

HEALTH DEPARTMENT—CITY OF BALTIMORE

G49589 — 83a G49589

CERTIFICATE OF DEATH

Registered No.....

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3512 O'Donnell St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ...yrs...mos...ds. How long in U. S. If of foreign birth? ...yrs...mon...ds.

2. FULL NAME George M. Behr

(a) Residence: No. 3512 O'Donnell St. St. 26-9 Ward. (If non-resident give city or town and State)
(Usual place of abode)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
M	W	M

5a. If married, widowed, or divorced — HUSBAND of (or) WIFE of: Lillian A. Koch

6. DATE OF BIRTH (month, day, year) Jan. 6, 1873

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	74	2	7	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Laborer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore Md.

FATHER

13. NAME Conrad

14. BIRTHPLACE (city or town) (State or country) Germany

MOTHER

15. MAIDEN NAME not known

16. BIRTHPLACE (city or town) (State or country) Germany

17. INFORMANT Lillian A. Behr
(Address) 3512 O'Donnell St.

18. BURIAL, CREMATION, OR REMOVAL
Place Schwartz Date 3/17/47 19...

19. UNDERTAKER Clarence F. Hoffmann
(Address) 1639 Broadway.

20. MAR 14 1947 19... Huntington Williams M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) March 13, 1947

22. I HEREBY CERTIFY, That I attended deceased from July ... 1946 to March 13 1947
I last saw him alive on March 12 1947. Death is said to have occurred on the date stated above, at 2:45 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	3-11-47

Other contributory causes of importance:

Arterio-sclerosis	Unknown

Name of operation None Date of

What test confirmed diagnosis? Phys. Ex. Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? Date of injury ... 19...
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) J. A. Rosenblatt M. D.
(Address) 3018 O'Donnell St. Balto. Md.

N. B.—WHITE PAPER. Information should be carefully supplied. AGE must be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Entire OCCUPATION is very important. See instructions on back of certificate.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30

Registered No. G43590

CWK-8560 G43590

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6- 10- 5-
(e) Length of stay in Baltimore (yrs., mos., or days) 66 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (2)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 650 Pitcher Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Albert Cooper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife Ellen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 9-1857

8. AGE: Years	Months	Days	If less than one day
90	1	2	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name James Cooper
13. Birthplace Maryland

MOTHER
14. Maiden Name Maria Roberts
15. Birthplace Delaware

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-14-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore Md.

18 (a) Funeral director Geo. A. Utz & Sons
(b) Address 1631 Druid Hill Ave.

19 (a) (Date received by Registrar) (b) MAR 14 1947 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1947 at 7:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 6 1947 to March 11 1947, and that I last saw him alive on March 11 1947

Immediate cause of death	Duration
Dissecting abd. Aortic Aneurysm	
Due to Arteriosclerotic C-V Disease	
Due to	
Other Conditions Benign Prostatic Hypertrophy (include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert R. Fowler M. D.
Address Balto City Hosp. Date signed 3-11-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49591

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G49591 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 16
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1011 W. Lafayette Ave (If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Willie Chappell

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Mary Carr

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 24, 1899

8. AGE: Years	Months	Days	If less than one day
47	6	18	..... hr. ..... min.

9. Birthplace Victoria, Va (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business .....

FATHER
12. Name John Chappell
13. Birthplace Victoria Va

MOTHER
14. Maiden Name Elizabeth Hamlett
15. Birthplace Victoria Va

16 (a) Informant Mrs. Mary Chappell
(b) Address 1011 W. Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/14/1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Balto. Co. Md.

18 (a) Funeral director Mrs. Geo. F. Holland
(b) Address 1631 Druid Hill Ave

19 (a) ..... (Date received by registrar) MAR 11 1947 (b) Huntington Williams Registrar

VS 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given. Make the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1947, at 9:30 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
Means of injury .....

23. Signature Earl L. Royer M.D. Medical Examiner.
Date signed 3-11-47

X'

G19592

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 169

G19592 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Every item correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 1/2 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1100 W Mulberry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Harold Ford

3 (b) If veteran, name war

3 (c) Social Security Account No. 717-07-7557

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Vangella

6 (c) If alien, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 14, 1896

8. AGE: Years	Months	Days	If less than one day
50	2	29	hr. min.

9. Birthplace Richmond, Va
(Town, county, and state)
10. Usual Occupation Porter
11. Industry or business Pa. R.R.

FATHER
12. Name Beverly Ford
13. Birthplace Gaitain, Va

MOTHER
14. Maiden Name Annie L. Whites
15. Birthplace Richmond, Va

16 (a) Informant Mrs. Vangella Ford
(b) Address 2116 McCulloh St.

17 (a) Burial (b) Date thereof 3-14-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Family lot
Location Richmond, Va

18 (a) Funeral director Mrs. Law. H. Holland
(b) Address 631 Druid Hill Ave.

19 (a) MAR 14 (b) 1947 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1947, at 2:35 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia

Due to

Other Conditions Fractures and traffic ulcers.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-22-47 at 12:06 A. M.(?) 11/2
(b) Where did injury occur? Pennsylvania R.R. Yard
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial Place While at work? no
(d) Means of injury Struck by train while waiting on platform

23. Signature Howard J. Weaver M.D.
Medical Examiner.
Date signed 3-13-47

VS 151

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Birth Certificate
G49593 G-79591

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
159

X ✓ G49593 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT & SARATOGA STS.
(c) Hospital or institution: MERCY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) 2 DAYS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Baltimore
(c) City or town BALT. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2906 DUBOIS E. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BABY BOY TAGG.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/11/47

8. AGE: Years | Months | Days 2 | If less than one day hr. min.

9. Birthplace BALT. MD. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name WESTLEY TAGG.
13. Birthplace W. Va.

MOTHER
14. Maiden Name Ruth ?
15. Birthplace W. Va.

16 (a) Informant Hospital Records
(b) Address Calvert & Saratoga Sts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-14-47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto. Co. Md.

18 (a) Funeral director L. J. Ryer
(b) Address 5305 Harford Rd.

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 14 1947 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-13 1947, at 7:22 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-12 1947 to 3-13 1947; and that I last saw him alive on 3-13 1947

Immediate cause of death RESP. FAILURE — Duration

Due to BILATERAL PULMONARY ATELECTASIS

Due to PREMATURITY.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James A. Roberts M. D.
Address Mercy Hospital Date signed 3-13-47

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133a

G49594 Registered No. G49594

G49594

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton and Wilkens Ave
(c) Hospital or institution: O. Hynes Hospital ward 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 622 Winslow Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME J. Lewis Johnson

3 (b) If veteran, name war
3 (c) Social Security Account No. 220-03-5842

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Grace Severson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 30, 1871

8. AGE: Years	Months	Days	If less than one day
75	3	12	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Lyon Conklin Co

FATHER
12. Name William Johnson
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Frances Abrahams
15. Birthplace Maryland

16 (a) Informant Mrs John L Johnson (Wife)
(b) Address 622 Winslow Rd

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof March 15, 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3501 Frederick Rd

18 (a) Funeral director Harry N Wyke
(b) Address 4101 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams

MAR 14 1947

MEDICAL CERTIFICATION A.

20. DATE OF DEATH 3/12 1947, at 7:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/18 1947 to 3/12 1947, and that I last saw h[illegible] alive on 3/12 1947.

Immediate cause of death	Duration
a Bronchopneumonia	
Due to Bronchopneumonia following	
Due to Senile Fracture (Rt hip)	
Other Conditions Recent operated (2 mos. ago)	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. A. Lampley M. D.
Address H. Agnes Hosp. Date signed 3-14-47

G49595

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G49595

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1732 N. Ashburton
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1732 Ashburton St (If rural, give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country

3 (a) FULL NAME Frank G. Rochester, Jr.

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 216-24-5274

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 19, 1891

8. AGE: Years 55 | Months 4 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation -

11. Industry or business

FATHER
12. Name Frank A. Rochester
13. Birthplace Baltimore

MOTHER
14. Maiden Name Lillia W. Goldsborough
15. Birthplace Baltimore

16 (a) Informant Mr. Samuel S. Rochester
(b) Address 5103 Eugene Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/15/47 (month) (day) (year)
(c) Cemetery or crematory Greenmount Vault
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) (Registrar)

MAR 14 1947

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MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1947 at 11 P.M

21. I certify that death occurred on the date above stated, that I attended deceased from Feb. 17 1947 to March 12 1947 and that I last saw h-- alive on March 11 1947.

Immediate cause of death: Coronary occlusion — Duration 6 hrs
Due to: Myocarditis — 3 years
Due to: Hypertension — 4 years
Other Conditions: Pulmonary Tb. 12 years ago
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
Confirmed by Electrocardiograph
of autopsy: tically.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 3812 Greenmount Date signed 3/12/47

Hunting for Millionaires

X

C49596

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

C49596 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33d. & Guilford Ave.
(c) Hospital or institution:
Union Memorial Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2610 Elsinore Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond Lee Myerly

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Henrietta D. Myerly
6 (c) If alive, give age ? years
7. Birth date of deceased (mo., day, yr.) July 4, 1902
8. AGE: Years 44 Months 8 Days 9 If less than one day ____ hr. ____ min.
9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation: Salesman
11. Industry or business ?

FATHER
12. Name: Golson Lee Myerly
13. Birthplace Maryland

MOTHER
14. Maiden Name: Sophie Worthington
15. Birthplace Maryland

16 (a) Informant: Hospital records
(b) Address 33d. & Guilford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) ____ (Date of d'r received by reg'r) (b) ____ Registrar

MAR 14 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13, 1947, at 8:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 22, 1947 to March 13, 1947 and that I last saw him alive on March 13, 1947

	Duration
Immediate cause of death: Coronary occlusion	7
Due to: Arteriosclerosis of the coronary artery	7
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norman R. Freeman M. D.
Address Union Memorial Hosp. Date signed March 13 1947

X

G49597

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G49597

Every item of information should be given. Please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 50 N. Prospect Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUIS Elmer REICH

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: Ellen Reich

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/4/[illegible]

8. AGE: Years 56 | Months [illegible] | Days 8 | If less than one day hr. min.

9. Birthplace: MARYLAND (Town, county, and state)

10. Usual Occupation: PRINTER

11. Industry or business: PRINTING

FATHER
12. Name: JACOB J. REICH
13. Birthplace: GERMANY

MOTHER
14. Maiden Name: BERNADINE E SERP
15. Birthplace: GERMANY

16 (a) Informant: ELLEN REICH
(b) Address: 50 N. PROSPECT AVE -28-

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-15-47 (month) (day) (year)
(c) Cemetery or crematory: Baltimore National Cemetery
Location: BALTIMORE - MD

18 (a) Funeral director: EDW. S. MACNABB
(b) Address: CATONSVILLE - MD - 28

19 (a) (Date rec'd by registrar) MAR 14 1947 (b) Huntington Willis, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13, 1947, at 9.35 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Subarachnoid Hemorrhage (Spontaneous)

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Earl C Royer M.D.
Medical Examiner

Date signed 3-13-47

G49598

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G49598

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Corner Redwood & Greene Sts.
(c) Hospital or institution: University Hospital 14-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ds.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 428 S. Fulton St (If rural give location)
(e) Citizen of foreign country? (Yes or No) Yes
If yes, name country

3 (a) FULL NAME Anna Carey

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-18-3879

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Joseph F. Carey (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 7, 1900

8. AGE: Years 46 | Months 7 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER
12. Name Dominick F. Monahan
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Lavin
15. Birthplace Ireland

16 (a) Informant Mrs. Agnes M. Sinclair
(b) Address 9 Gittens ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 17 1947 (month) (day) (year)
(c) Cemetery or crematory St. Peters
Location Baltimore

18 (a) Funeral director Frederick A. Cole
(b) Address 120 W. Lombard St

19 (a) (Date rec'd by registrar) MAR 14 1947 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13, 1947, at 1 Ca M

21. I certify that death occurred on the date above stated; that I attended deceased from March 11, 1947, to March 13, 1947, and that I last saw h.e.r. alive on March 12, 1947.

Immediate cause of death	Duration
Congestive Heart Failure	
Due to Coronary Occlusion	
Due to Hypertensive Cardio Vascular Disease	
Other Conditions Broncho Pneumonia	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Gray M. D.
Address University Hospital Date signed 3-13-47

X

G49599

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83B

G49599 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4315 Raspe Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 + 1
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4315 Raspe Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Rosina Fowler

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: James H. Fowler | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 10, 1864

8. AGE: Years	Months	Days	If less than one day
82	7 M	4	hr. min.

9. Birthplace Prince George Co. Md. (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER — 12. Name Conrad Lober

13. Birthplace Germany

MOTHER — 14. Maiden Name Mary Ockhard

15. Birthplace Denmark

16 (a) Informant W. H. Fowler

(b) Address 4315 Raspe Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 17 47 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Balto. Md.

18 (a) Funeral director Lansburgh & Funeral Home

(b) Address 7401 Belair Rd.

19 (a) (Date rec'd by registrar) (b) Huntington Williams MAR 14 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1947 at 3 45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 8 1947 to March 14 1947 and that I last saw her alive on March 13 1947

Immediate cause of death: Cerebral Embolus — Duration: 6 days

Due to: Auricular Febrillation — Duration: 1 year

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide no

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Joseph Pokorny M. D.

Address 210 E Madison St Date signed 3/14/47

X

G15600

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G15600

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 6000 Bellona ave Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ---
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 719 W. University Pkwy. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM J. LOVE

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	Married

6 (b) Name of husband or wife Sunshine Love
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Aug. 9, 1874

8. AGE: Years	Months	Days	If less than one day
72	7	3 4	..... hr. ..... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Retired, Vice Pres.
11. Industry or business Shipping Business

FATHER
12. Name William H. Love
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Crangle
15. Birthplace Balto. Md.

16 (a) Informant Mrs. William J. Love
(b) Address 719 W. University Pkwy.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/15/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location

18 (a) Funeral director Chas. J. Evans Son Inc
(b) Address 118 N. Mt. Royal Ave

19 (a) MAR 14 1947 (b) (Date received) Registrar for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1947 at 10 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to March 13 1947. and that I last saw him alive on 3/12 1947

Immediate cause of death: Myocarditis — Duration: Gradual
Due to: Arteriosclerosis Hypertension
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature W H Moody
Address 1403 Park ave Date signed 3/14/47

VS 150

5 1 5 3 5 9 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

Registered No. C 49601

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3018 ROSELAWN AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~[illegible]~~ HENRY LEONARD

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-16-5931

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife ANNA LEONARD
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) DEC. 21, 1884

8. AGE: Years	Months	Days	If less than one day
62	2	20	hr. min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual Occupation
11. Industry or business SHIPPING

FATHER
12. Name THOMAS LEONARD
13. Birthplace MARYLAND

MOTHER
14. Maiden Name MARY Theis
15. Birthplace GERMANY

16 (a) Informant RECORDS
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/47 (month) (day) (year)
(c) Cemetery or crematory Maryland Park
Location Taylor ave

18 (a) Funeral director Harvey M. Blight Jr
(b) Address 6009 Harford Road

19 (a) (Date rec'd by registrar) (b) Registrar

VS FORM MAR 14 1947 Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1947, at 2 WP M

21. I certify that death occurred on the date above stated; that I attended deceased from March 12 1947, to March 13 1947, and that I last saw him alive on March 11 1947.

Immediate cause of death	Duration
Heart Failure	2 days
Due to Pneumonectomy	2 weeks
Due to Carcinoma of Lung	3 mo
Other Conditions None (Include pregnancy within 3 months of death)	

Date of operation 2/22/47
Major findings of operation: Advanced carcinoma right lung
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas N P Johns
Address Johns Hopkins Hosp Date signed 3/13/47

X

G49603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V186a

Registered No. G49603

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 809 S. Fremont Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 809 S. Fremont Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Ida Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20, 1888

8. AGE: Years 58 | Months 9 | Days 23 | If less than one day hr. min.

9. Birthplace Manning South Carolina (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Charles Gamble
13. Birthplace Manning South Carolina

MOTHER
14. Maiden Name Debbie Harvin
15. Birthplace Manning South Carolina

16 (a) Informant Charles Miller (Son)
(b) Address 809 South Fremont ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 15, 1947 (month) (day) (year)
(c) Cemetery or crematory Florence Co Cemetery
Location Florence County

18 (a) Funeral director Joseph A. Lively
(b) Address 610 West Cane Street

19 (a) (Date rec'd by registrar) 1947 (b) Registrar

VOID 1 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12, 1947, at 8 a. M.

21. I certify that I took charge of the remains described above, held an insp. & inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Broncho-pneumonia

Due to

Other Conditions: Fracture of tibia and fibula. Decubital ulcers.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☒ cause of death, fill in the following: 22/2

(a) Date of injury 2-7-47 at 6 p. M.
(b) Where did injury occur? 809 S. Fremont Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fell down flight of stairs

23. Signature Howard J. Williams M.D. Medical Examiner.
Date signed 3-12-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

~~64,603~~ 1170

Registered No. 64,603

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkins Aves.
(c) Hospital or institution:
St. Agnes Hospital 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1014 W. Cross St.
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph M. Voyce

3 (b) If veteran, name war ~ | 3 (c) Social Security Account No. ~

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed, or divorced~~
Male	White	Single

6 (b) Name of husband or wife ~
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 2nd 1915

8. AGE: Years	Months	Days	If less than one day
31	5	11	hr. min.

9. Birthplace Md. Balto. (Town, county, and state)
10. Usual Occupation machinist
11. Industry or business U. S. Govmt.

FATHER
12. Name George Voyce
13. Birthplace Md. Balto.

MOTHER
14. Maiden Name Theresa Hurbert
15. Birthplace Ireland

16 (a) Informant Mrs Bridget T. Voyce
(b) Address 1014 W. Cross St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/47 (month) (day) (year)
(c) Cemetery or crematory New Catholic Cem.
Location 4300 Old Frederick Rd.

18 (a) Funeral director John J. Logan & Son
(b) Address 901-03 Hollins St.

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 14 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/13 1947, at 5:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/6 1947, to 3/13 1947, and that I last saw him alive on 3/13 1947.

Immediate cause of death	Duration
Acute cardiac dilatation and congestive changes	3 days.
Due to Post operative gastric resection —	
Due to Gastric ulcer and chronic low grade duodenal	14 yrs.
Other Conditions	2 wks.

(Include pregnancy within 3 months of death)
Date of operation 3 March 47
Major findings of operation: Adhesions scarring and obstruction —
of autopsy: — as above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alfred Harrison M.D.
Address St Agnes Hosp. Date signed 3/14/47

Huntington Williams M.D.

C49604

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

C49604 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1915 Belair road
(c) Hospital or institution: 8-E

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1915 Belair Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frank J.Kreuzer

3 (b) If veteran, name war None

3 (c) Social Security Account No. 214-24-8206

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Rosetta A.Dunn

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Jan. 26, 1882

8. AGE: Years 65 | Months 1 | Days 18 | If less than one day ##### hr. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business U.S.Post Office

FATHER
12. Name Casper Kreuzer
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Getz
15. Birthplace Germany

16 (a) Informant Mrs. Rosetta A.Kreuzer (Wife)
(b) Address 1915 Belair Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director George J.Ruth, Inc.
(b) Address 1735 Harford Avenue

19 MAR 14 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/14 1947, at 8 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1 1946 to 3/14 1947, and that I last saw h/m alive on 2/11 1947

	Duration
Immediate cause of death: Coronary Thrombosis	Sudden
Due to: Arteriosclerotic Cardio-Vascular Renal Disease	?
Due to:	
Other Conditions: Varicose Ulcer with Leg	15 Yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph L. Blum M.D.
Address 1206 E. Preston St Date signed 3/14/47

FG19605

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No. G19605

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Corner Redwood & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Ellicott City (If outside city or town limits, write RURAL, and give town)
(d) Street No. College Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Bertie Albright

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Nelson Albright
6 (c) If alive, give age: 35 years

7. Birth date of deceased (mo., day, yr.): May 16, 1916

8. AGE: Years: 30 | Months: 11 | Days: 27 | If less than one day: hr. min.

9. Birthplace: Hawkins Co. Tenn. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Camb. Miller
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Cynthia Bishop
15. Birthplace: Virginia.

16 (a) Informant: Nelson Albright
(b) Address: Ellicott City, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Mar. 15, 1947 (month) (day) (year)
(c) Cemetery or crematory: Taylor Family
Location: Granite, Md.

18 (a) Funeral director: Easton Sons
(b) Address: Ellicott City, Md.

19 (a) MAR 14 1947 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13, 1947, at 3:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 14, 1947 to March 13 1947, and that I last saw h.r alive on March 13, 1947.

Immediate cause of death: Acute Myelogenous Leukemia — Duration:

Due to:

Due to:

Other Conditions: Anaemia, Cachexia

(Include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: None
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:
23. Signature:
Address: University Hospital Date signed 3-13-47 M. D.

Birth certificate
G-43461

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1600

G43506
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Zeiler St
(c) Hospital or institution:
University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day 9 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day 9 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Anne Arundel
(c) City or town Pines on Severn
(If outside city or town limits, write RURAL and give town)
(d) Street No. (rural) (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Williams

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife: None
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/10/47

8. AGE: Years	Months	Days	If less than one day
		1	9 hr. 22 min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Russell Williams
13. Birthplace Md.

MOTHER
14. Maiden Name Augusta Heisler
15. Birthplace Md.

16 (a) Informant Mrs Williams
(b) Address Pines on Severn

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Loc Johns Hopkins Medical School

18 (a) Funeral director
Address

19 (a) (Date rec'd by registrar) Registrar

MAR 14 1947
MAR 14 1947
Commissioner of Health

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/11 1947 at 6:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/10 1947 to 3/11 1947 and that I last saw him alive on 3/11 1947

Immediate cause of death

Due to: Prematurity

Due to: Cerebral Hem + atelectasis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. D.
Address Date signed 3/11/47

Birth Certificate

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G-75226 V159

Registered No. G12607

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Where exact date is not known, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1514 Division St.

(c) Hospital or institution: Provident Hospital 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr

(e) Length of stay in Baltimore (yrs., mos., or days) 1 hr

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 620 N. Gilmor St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby of Ruby Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7, 1947

8. AGE: Years	Months	Days	If less than one day
			1 hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Delmo Harris

13. Birthplace Youngsville N.C.

MOTHER

14. Maiden Name Ruby Moore

15. Birthplace Granville county N.C.

16 (a) Informant Ruby Harris

(b) Address 620 N. Gilmor St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location Johns Hopkins Medical School MAR 14 1947

18 (a) Funeral director Commissioner of Health

(b) Address

MAR 14 1947 (Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7, 1947, at 6.30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 7, 1947 to Mar 7, 1947, and that I last saw her alive on Mar 7, 1947.

Immediate cause of death	Duration
Pre-maturity	6 hrs.
Due to Maternal Toxemia	1-3-7
Due to Pre-eclampsia	2-3 hrs
Other Conditions Bilateral dry foci in both lungs	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature R. Louis Jaeger M.D.

Address 1100 Druid Park Dr. Date signed 3/12/47

X

G42608 Baby Tyrusdale G-13287

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

G42608 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edmondson & Heme
(c) Hospital or institution: Univ. Hosp. 16-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 815 Fulton Ave N. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Tyrusdale.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Tyrusdale
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Bruce
15. Birthplace D. C.

16 (a) Informant Mary Tyrusdale
(b) Address 815 Fulton Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School MAR 14 1947
Commissioner of Health

18 (a) Funeral director
(b) Address

MAR 14 1947 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/9 1947, at 2:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/7 1947, to 3/9 1947, and that I last saw h[illegible] alive on 3/8 1947

Immediate cause of death Prematurity secondary

Due to

Due to

Other Conditions Prematurity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. W. Leyton
Address Univ. Hosp. Date signed 3/10/47 M. D.

X

C49609

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. C49609

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2124 N. Fulton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 ds
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 2124 N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME William C. Sutton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Theresa Sutton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 7-1874

8. AGE: Years 7 Months 5 Days 6 If less than one day hr. min.

9. Birthplace Charlestown Md.
(Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business Retired

FATHER
12. Name William Thomas Sutton
13. Birthplace Kent Co. Md.

MOTHER
14. Maiden Name Mary E. Burch
15. Birthplace Kent Co. Md

16 (a) Informant Mrs Antoinette Perry
(b) Address 2124 N. Fulton Ave.

17 (a) Burial (b) Date thereof 3.16.37
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Chesterwood Cem.
Location Chestertown Md

18 (a) Funeral director W. J. Tucker & Son
(b) Address 20 & Pa. - Balto Md

19 (a) MAR 14 1937 (b) Easton for Williamsport
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 13 1937, at 8:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 7- 1937, to Mar 13 1937, and that I last saw h. alive on Mar 12 1937.

Immediate cause of death	Duration
Cerebral Hemorrhage	3/7/37
Due to	
Due to Chr. Myocarditis	1933
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jane Brown M. D.
Address 1663 W. North Ave. Date signed 3/13/37

VS 150

G49610

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1923 Registered No. G49610

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hosp. 28
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5603 Norwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Allen E Pfeil

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Bertha O. Pfeil
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec. 29, 1889
8. AGE: Years 57 | Months 2 | Days 14 | If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Md. Trust Co.

FATHER
12. Name John William Pfeil
13. Birthplace Md.

MOTHER
14. Maiden Name Caroline Winters
15. Birthplace Westminster, Md.

16 (a) Informant Mrs. H. A. Sharpe
(b) Address 116 Corlies Ave., Pelham, N.Y.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.
19 (a) MAR 14 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13, 1947, at 8:00 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw h alive on 19
Immediate cause of death Cardiac Failure
Due to Degenerative Heart Disease with Mitral Stenosis
Due to and Insufficiency
Other Conditions Terminal Pneumonia
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Gladston Smith Jr. M.D.
Address St. Agnes Hosp Date signed 3/13/47

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G19611

G19611 ✓107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2447 Washington Blvd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 341 S. Lehigh Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles E. Schaller Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male.	White	Married

6 (b) Name of husband or wife Barbara Schaller
6 (c) If alive, give age 82 years

7. Birth date of deceased (mo., day, yr.) Nov. 22 1866

8. AGE: Years	Months	Days	If less than one day
80	3	9. 19	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired fr. Dr. Packing Co
11. Industry or business

FATHER
12. Name Ludwig Schaller
13. Birthplace Germany

MOTHER
14. Maiden Name Francesca Lohmann
15. Birthplace Germany

16 (a) Informant Norman Schaffer
(b) Address 343 S. Newkirk St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 15 1947 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North ave. Extd.

18 (a) Funeral director Wendell P. Appel
(b) Address 3411 E. Highland Ave

MAR 14 1947 (Date rec'd by registrar) (b) Huntington, Williamsport

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1947, at 7.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1947 to March 11 1947, and that I last saw h. alive on March 11 1947.

Immediate cause of death Cardio Resp. Failure

Due to Broncho Pneumonia

Due to

Other Conditions Chronic Arterio Sclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

Duration
8 days
10 years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles Lowman Jr. M. D.
Address 9 Court Lombard Date signed 14 March 47

X

G49612

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Register G49612

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address DUKELAND & RAYNOR STS.
(c) Hospital or institution:
WEST BALTIMORE GENERAL HOSP
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State PA. (b) County Cumberland
(c) City or town SHIPPENSBURG
(If outside city or town limits, write RURAL and give town)
(d) Street No. 477½ E. King Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME STEVEN LEWIS

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex MALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Viola Gallos

6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Jan. 18, 1883

8. AGE: Years	Months	Days	If less than one day
64	1	26	hr. min.

9. Birthplace Greece
(Town, county, and state)

10. Usual Occupation Retired Merchant

11. Industry or business Food and Beverage

FATHER
12. Name James Lewis
13. Birthplace Greece

MOTHER
14. Maiden Name Mary Proferis
15. Birthplace Greece

16 (a) Informant
(b) Address Shippensburg, Pa.

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 3-15-47 (month) (day) (year)

(c) Cemetery or crematory
Location SHIPPENSBURG, PA.

18 (a) Funeral director Wm. T. Tickner & Son
(b) Address North & Penna. Aves

19 MAR 15 1947 (Date rec'd by registrar) (c) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14, 1947 at 10:57 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/11 1947 to 3/14 1947 and that I last saw him alive on 3/14 1947

Immediate cause of death MYOCARDIAL INFARCTION — Duration
CARDIAC DECOMPENSATION
Due to CORONARY ARTERY DISEASE
Due to
Other Conditions DIABETES MELLITUS
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gilbert Rutrauterberg
Address 300 E. North Ave. Date signed 3/15/47

VS 150

94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

049613 Birth Certificate B-73822 — BALTIMORE CITY HEALTH DEPARTMENT — 159 — Register 049613

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 43min.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2815 O'Donnell Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Gugliotta-Twin A.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 14-1947
8. AGE: Years | Months | Days | If less than one day: hr. 43min.
9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name (Otto) Gugliotta
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary (Ketchum) Ketchum
15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-15-47 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location North Ave & Miller Lane

18 (a) Funeral director Wm. E. Oliver
(b) Address 2445

19 (a) MAR 15 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION AM

20. DATE OF DEATH March 14 1947, at 9:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-14- 1947 to 3-14 1947, and that I last saw him alive on 3-14- 1947.

Immediate cause of death	Duration
Apparently 4½ months Premature	
Due to weight 10 g	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Benjamin A. Hoag, M.D.
Address Balto City Hosp Date signed 3/17/47

VS 150

G49614 Birth certificate G-13823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G49614

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4hrs-11min.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2815 O'Donnell Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Cugliotta-Twin B

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 14-1947

8. AGE: Years	Months	Days	If less than one day
			4 hr. 11min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Otho Cugliotta
13. Birthplace Maryland

MOTHER 14. Maiden Name Mary Ketchem Ketchum
15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-15-47 (month) (day) (year)
(c) Cemetery or crematory Balto Cem
Location North Ave
18 (a) Funeral director John F. Miller Jr
(b) Address 243 E Pratt St
19 (a) MAR 15 1947 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1947, at 1PM M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-14- 1947 to 3-14- 1947, and that I last saw him alive on 3-14 1947.

Immediate cause of death	Duration
Prematurity	life
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wilson E. Hughes M. D.
Address Balto City Hall Date signed Mar 14 '47

X

G49615 Death Certificate D-73239

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G49615

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Somerset
(c) City or town Chance
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Infant Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12, 1947

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name McKinley Jones
13. Birthplace Maryland

MOTHER
14. Maiden Name Crystal Beckett
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof 3 15 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Baltimore

18 (a) Funeral director Gatta & Sons
(b) Address 1501 Orleans St.

MAR 15 1947 (Date rec'd by registrar) (Signature) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1947, at 12:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 12 1947 to Mar. 13 1947 and that I last saw him alive on Mar. 13 1947.

Immediate cause of death Prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Russell Jordan M. D.

Address Johns Hopkins Hospital Date signed 3-14-47

VS 150

X

G49616

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4469

Registered No. G49616

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hosp'l.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Charleston (If outside city or town limits, write RURAL and give town)
(d) Street No. 1207 Cherokee Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles Rudel

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Lillian Rudel
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Mar 16 1901

8. AGE: Years	Months	Days	If less than one day
45	11	28	___ hr. ___ min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business C & P Tel. Co.

FATHER
12. Name Martin W. Rudel
13. Birthplace Md.

MOTHER
14. Maiden Name Frances Wiseman
15. Birthplace Md.

16 (a) Informant Self
(b) Address Store.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 17 1947 (month) (day) (year)
(c) Cemetery Cathedral
Location Balto., Md.

18 (a) Funeral director William Cook Inc.
(b) Address 17 St. Paul St.

MAR 15 1947
(Date rec'd by registrar) (b) Huntington, W. Va.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-14 1947, at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-4 1947, to 3-14 1947, and that I last saw him alive on 3-13 1947.

Immediate cause of death	Duration
generalized carcinomatosis	
Due to	over
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: generalized carcinomatosis abdominal
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Emp K Riggs M.D. M. D.
Address Univ. Hosp. Date signed 3-14-47

X

G49617

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 557

Registered No. G49617

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3408 Chessell Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3408 Chessell Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EMIL ALBERT KEIM

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	white	widowed

6 (b) Name of husband or wife: Rosa
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 14 187?

8. AGE: Years	Months	Days	If less than one day
75	2	-	hr. min.

9. Birthplace Towson, Maryland (Town, county, and state)
10. Usual Occupation Painter - Domestic
11. Industry or business

FATHER
12. Name Unknown Keim
13. Birthplace Germany

MOTHER
14. Maiden Name Paulin Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Mildred Finney
(b) Address 3408 Chessel Court, Fairfield

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) (b)

(Date rec'd by Registrar) MAR 15 1947 Registrar

US 750

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 14th 1947, at [illegible] M

21. I certify that death occurred on the date above stated; that I attended deceased from March 20 1947, to March 14 1947, and that I last saw h[illegible] alive on March 13 1947.

Immediate cause of death: (a) Uraemia (b) Cardiac Decompensation (c) Arteriosclerosis Duration: 1 week

Due to: (a) (b) Arteriosclerosis (c) Prostatism

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 700 Lexington Date signed 3/14/47

G49618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30D

Registered No. G49618

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be answered or "unknown" written. Do not write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: President Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1403 Madison Avenue
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Samuel Hall

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-05-7484

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	married

6 (b) Name of husband or wife Grace P. Hall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24-1910

8. AGE: Years	Months	Days	If less than one day
36	8	19	.....hr. .....min.

9. Birthplace Balto
(Town, county, and state)
10. Usual Occupation manager
11. Industry or business Hotel

FATHER
12. Name Robert Hall
13. Birthplace md

MOTHER
14. Maiden Name Frances —
15. Birthplace md

16 (a) Informant Grace Parker Hall
(b) Address 1403 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-16-47 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location.....

18 (a) Funeral director James A Sayer
(b) Address 1142 W. Ostend St.

19 MAR 15 1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1947, at 1:25 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Gastric Hemorrhage

Due to Chronic Gastritis

Other Conditions Syphilitic Aortitis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Earl L. Royer M.D.
Medical Examiner.
Date signed 3-13-47

VS 191

G49619

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered G49619

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3834 Yolando Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3834 Yolando Rd
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy M. Sprecht

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Robt L Sprecht

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Dec 5 1895

8. AGE: Years 51 | Months 3 | Days 9 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER
12. Name Fleetwood C Kautz
13. Birthplace Balto

MOTHER
14. Maiden Name Annie Arenser
15. Birthplace Balto

16 (a) Informant Kenneth L. Sprecht
(b) Address 3834 Yolanda Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 17
(month) (day) (year)

(c) Cemetery or crematory Ark Lawn
Location Catonsville

18 (a) Funeral director Ulrich Funeral Home
(b) Address 200 E Orleans St

MAR 15 1947 (Date filed by Registrar)

(b) Huntington Williams, M.D. Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14th 1947, at 2 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-10 1947 to 3-14 1947 and that I last saw her alive on 3-14 1947

Immediate cause of death Acute Cardiac Collapse — Duration 12a

Due to Carcinoma of Bladder — 2yr

Due to with Metastases

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph H. L. Aurbach M. D.

Address 6716 Washington Blvd (Date signed) 3/15/47

G49620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

Registered No. G49620

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2415 Etting St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimor (If outside city or town limits, write RURAL and give town)
(d) Street No. 2415 Etting St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Matelda Hatrick

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F. | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced M

6 (b) Name of husband or wife Ernest

6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Aug. 31, 1896

8. AGE: Years 50 | Months 6 | Days 12 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name James Robinson
13. Birthplace md.

MOTHER 14. Maiden Name Caroline Sytich
15. Birthplace md.

16 (a) Informant Ernest Hatrick
(b) Address 2415 Etting Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/15/47 (month) (day) (year)
(c) Cemetery or crematory Sturmsville Md
Location

18 (a) Funeral director Sarah L. Brownson
(b) Address 1018 Montgomery St

19 (a) (b) Huntington Md. (City or town) (State)

MAR 15 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-12-1947 at 8:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 6 1946 to March 1947. and that I last saw her alive on 3-11-1947.

Immediate cause of death Cerebral Hemorrhage — Duration 6 days
Due to Hypertension — 9 mos
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George Page M.D.
Address 1516 N. Monroe St. (Date signed) 3-14-47

49621

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 49621

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Bradshaw
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorthy Ayers

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	—

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/1946

8. AGE: Years	Months	Days	If less than one day
	3		hr. min.

9. Birthplace Bradshaw
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Chas. Ayers
13. Birthplace Bradshaw

MOTHER
14. Maiden Name Lilian Elliott
15. Birthplace Bradshaw

16 (a) Informant Chas Ayers
(b) Address Bradshaw

17 (a) (Burial, cremation, or removal) (b) Date thereof 3-15 1947 (month) (day) (year)
(c) Cemetery or crematory Salem Cemetery
Location Upper Falls -

18 (a) Funeral director David Garrison
(b) Address Upper Falls Md

19 MAR 15 1947 (Date rec'd by Registrar) (b) Huntington Williams Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 14 1947 at 5 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 12 1947 to Mar 14 1947 and that I last saw h alive on Mar 14 1947

Immediate cause of death Pneumonia

Due to

Due to

Other Conditions Pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Purulent meningitis

Duration
11 days
4 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address Sinai Hosp Date signed Mar 14

G49622

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

Register G49622

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline + Oliver
(c) Hospital or institution: St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore - 22
(If outside city or town limits, write RURAL and give town)
(d) Street No. 11 Lombard Drive
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** LORRAINE A. Billings

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-17-46

8. AGE: Years	Months	Days	If less than one day
	2	26	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Elmer
13. Birthplace Md.

MOTHER
14. Maiden Name Dora L.
15. Birthplace Md.

16 (a) Informant Elmer Billings
(b) Address 11 Lombardy Drive, Balto. 22, Md.

17 (a) Burial (b) Date thereof March 15, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Taylor Avenue.

18 (a) Funeral director Roland L. Fischer
(b) Address 2112 Dundalk Ave.

MAR 15 1947 Huntington Williams
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/14/1947, at 3:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/3/1947, to 3/14/1947, and that I last saw her alive on 3/14/1947.

Immediate cause of death	Duration
Cardiac - Acute Myocarditis	
Due to Rheumatic Endocarditis	
Due to Chorea	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Richard A. Young M. D.
Address St. Joseph Hosp. Date signed 3/14/47

X

G49623

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G49623

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 119 W. Franklin St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 — 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 119 W. Franklin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME Frances Eaton Weld

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Rev. Charles Richmond Weld
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 8 1857

8. AGE: Years 89 | Months 3 | Days 5 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name George N. Eaton
13. Birthplace New York N.Y.

MOTHER
14. Maiden Name Susan B. Mathew
15. Birthplace Bucks Md

16 (a) Informant Jas B. Diggs
(b) Address 1st Nat Bank Bldg

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Mar 17 1947 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Balto. Md.

18 (a) Funeral director Henry H. Jenkins Sons Co
(b) Address McCulloh & Orchard Sts

MAR 15 1947 (Registrar) Huntington Willis, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1947, at 11:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1925 to March 18 1947, and that I last saw h. alive on March 13 1947.

Immediate cause of death	Duration
Due to Carcinoma of colon	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Wm A. Hardy
Address 319 Cathedral Date signed 3 17 47 (M. D. Y.)

VS 150

G49624 BCHD 55942 BALTIMORE CITY HEALTH DEPARTMENT ✓ 104a Registered No. G49624

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Give the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Laverna Park
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Shirley - Anne - Gregg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 17- 1946

8. AGE: Years	Months	Days	If less than one day
1	8	27	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Lester L. Gregg
13. Birthplace Frederick County-Md

MOTHER
14. Maiden Name Frances M. Doody
15. Birthplace Baltimore Md.

16 (a) Informant Lester L Gregg
(b) Address Woodbine - Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 15 MAR-47 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glenburnie - Md.

18 (a) Funeral director F. P. Hepburn & Son
(b) Address 120 Eutaw Place

MAR 15 1947 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1947, at 12 50 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Last death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Uppar Respiratory Infection

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Gregg M.D.
Medical Examiner

Date signed 3-14-47

49625 L - 108959

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30E

Registered 49625

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 7-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 522 N. Duncan St -5 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

James Frederick Barnes

3 (a) FULL NAME Frederick Barnes, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-01-1278

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Cora
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 25, 1883

8. AGE: Years	Months	Days	If less than one day
63	10	18	hr. min.

9. Birthplace St. Mary's Co., Md. (Town, county, and state)

10. Usual Occupation Laborer
11. Industry or business D. P. W. (P.W. Trouble Lumber Co.)

FATHER
12. Name Edward Barnes
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Barnes
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Joppa Rd.

18 (a) Funeral director Robert L. Cromwell
(b) Address 1216 E. Caroline St.

19 (a) (Signature of registrar) (b) Huntington Williams, Registrar

MAR 13 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1947, at 5.15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 7 1947 to Mar. 13 1947 and that I last saw him alive on March 13 1947

Immediate cause of death Cardiac failure — Duration

Due to Senile C.V. disease

Due to Senile

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Senile C-V disease

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Doyle Watkins M. D.
Address B. C. H. Date signed 3-13-47

X

G49626

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G49626

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Every item must be answered or a satisfactory reason given why it cannot be answered. Be sure that the causes of death are stated clearly and legibly. Use only standard abbreviations. Do not use ditto marks. Be sure that the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1923- Eutaw Place
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1923- Eutaw Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DORIS B MOOREHEAD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Louis J. Moorehead
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 13, 1903

8. AGE: Years	Months	Days	If less than one day
43	7	2	hr. min.

9. Birthplace Canada (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name William Craig
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Louis J Moorehead
(b) Address 1923 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-17-47 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Windsor Mill Road

18 (a) Funeral director John O Mitchell
(b) Address 1960 Eutaw Pl.

19 (a) MAR 15 1947 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15, 1947, at 7.30 a.m.

21. I certify that I took charge of the remains described above, held an insp.& inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Respiratory Failure
Cardio-vascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Weaver M.D. Medical Examiner.
Date signed 3-15-47

X

VS 151

G49627

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G49627

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1502 Mc Culloh St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1502 Mc Culloh St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Roye

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17 1848

8. AGE: Years 98 | Months 7 | Days 19 | If less than one day hr. min.

9. Birthplace Maryland (town, county, and state)

10. Usual Occupation Housework

11. Industry or business at home

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Furman Templeton
(b) Address 1502 Mc Culloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 15 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) MAR 15 1947 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-6 1947, at 12:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 12 1947 to 3-6 1947, and that I last saw her alive on 3-4 1947

Immediate cause of death: arterio-sclerotic cardiac disease — Duration: over 5 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rayner Browne M. D.

Address 1 S W E. Mad. St Date signed 3-10-47

VS 150

Rayner Browne x

G49628 Birth Certificate

G. 13784

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160c

Registered No. G49628

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave & Dukeland St
(c) Hospital or institution West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2606 Loretta Ave (If rural give location)
(e) Citizen of foreign country? [redacted] No (Yes or No)
If yes, name country

3 (a) FULL NAME Jesse Francis Stacey Jr

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3- 3/14/47

8. AGE: Years 0 | Months 0 | Days 1 | If less than one day 3 hr. 10 min.

9. Birthplace West Baltimore Gen Hosp (Town, county, and state)

10. Usual Occupation infant

11. Industry or business

FATHER
12. Name Jesse Francis Stacey Sr.
13. Birthplace ?

MOTHER
14. Maiden Name Rosalie Colamplia
15. Birthplace Baltimore Md

16 (a) Informant Hospital
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-15-47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location

18 (a) Funeral director Joseph Isaac Inc
(b) Address 2013 Freemount

19 (a) Filed MAR 15 1947 Registrar Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-15 1947, at 2.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-14 1947, to 3-15 1947, and that I last saw him alive on 3-15 1947

Immediate cause of death Respiratory failure — Duration

Due to Unknown

Due to

Other Conditions Possible Intra-Cranial Hemorrhage (Include pregnancy within 3 months of death)

Date of operation Breech Delivery

Major findings of operation:

of autopsy: Not obtained

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Dept Anes

Address W. Balto Gen Hosp Date signed 3-15-47 M. D.

VS 150

649629

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 649629

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1113 Penna ave
(c) Hospital or institution:
17-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1113 Penna ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Millie Mc Carthy

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	colored	Widowed

6 (b) Name of husband or wife Frank Mc Carthy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 19, 1869

8. AGE: Years	Months	Days	If less than one day
77	2	25	hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Washington Waters
13. Birthplace Va

MOTHER
14. Maiden Name Florenda Jessup
15. Birthplace Va

16 (a) Informant Florenda Hancum
(b) Address 1113 Penna ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-15-47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director George E. Nelson
(b) Address 1303 Boerstmann ST

19 Filed March 15 1947 H. Livingston Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1947, at 6.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-3 1947 to 3-13 1947, and that I last saw h[illegible] alive on 2-12 1947

Immediate cause of death Cardio Vascular Disease — Duration 1 Yr

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Atwell Jones M. D.
Address 535 N Dolphin St Date signed 3-15-47

VS 150

G49630 BAU G49630

BALTIMORE CITY HEALTH DEPARTMENT

Registered No.

CERTIFICATE OF DEATH 94a

1. PLACE OF DEATH: D.O.A.
(a) Baltimore City, Maryland
(b) Street address 5504 Woodcrest Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 5504 Woodcrest Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Bau

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Emma B.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 23, 1880

8. AGE: Years 66 | Months 5 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Proprietor Emanuel
11. Industry or business Meat Cutter

FATHER
12. Name Christian W. Bau
13. Birthplace Germany

MOTHER
14. Maiden Name Emma Marquardt
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs Emma B. Bau
(b) Address 5504 Woodcrest Road

17 (a) Burial (b) Date thereof 3-16-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Whitelock St Lukes Lutheran Cem
Location nr New Windsor Carroll Co. Md.

18 (a) Funeral director Loring Byers
(b) Address 5005 Park Heights Ave

19 (a) MAR 15 1947 (b) Registrar for Williams, M.D.
(Date rec'd by registrar)

VS 131

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/13 1947, at 6:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. F. Gubinski, M.D.
Medical Examiner.
Date signed 3/13/47

X

G49631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122 B

Register G49631

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully examined for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 months
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Middle River
(If outside city or town limits, write RURAL and give town)
(d) Street No. Yaumeter Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Powers LEE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, ~~married, widowed, or divorced~~: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 29th 1944

8. AGE: Years 2 | Months 10 | Days 14 | If less than one day ... hr. ... min.

9. Birthplace Annapolis Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Walter Powers
13. Birthplace Georgia

MOTHER
14. Maiden Name ~~Mary~~ Marion L. Grant
15. Birthplace N. J.

16 (a) Informant Relative
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 17th 1947 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Sacred Heart
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) MAR 15 1947 (Date received by registrar) (b) Harold F. Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1947 at 8.40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-13 1947 to 3-13 1947 and that I last saw him alive on 2-13 1947

Immediate cause of death Cardiac + respiratory failure. — Duration

Due to Intestinal Obstruction

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Burton Childs M. D.
Address Johns Hopkins Hosp Date signed 3-14-47

VS 150

To be approved by Chief Medical Examiner Howard J. Helling M.D.

G49632 Birth Certificate

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

Registered G49632

B-73160

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 25-
(c) Hospital or institution: South Balto General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 2247 Cadley St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Beauchamp

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 14 1947

8. AGE: Years | Months | Days | If less than one day 6 hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Leonard V. Beauchamp

FATHER 13. Birthplace Unknown

MOTHER 14. Maiden Name Elizabeth Chaney

MOTHER 15. Birthplace Baltimore Md

16 (a) Informant Myrtle E Chaney

(b) Address 2247 Cadley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-16-47 (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location Ritchie Highway A.A. Co.

18 (a) Funeral director Wm Cook Inc

(b) Address 917 E. Paul St.

19 (a) MAR 15 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/14 1947, at 6 30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Atelectasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature O. P. Schwabe M.D. Medical Examiner.
Date signed 3/15/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 191

G49633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G49633

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Pier 6 Pratt St.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. C. (b) County Bertie
(c) City or town Aulander (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jessie Bazemore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 13 1882

8. AGE: Years 56 | Months 0 | Days 0 | If less than one day: hr. min. 1891

9. Birthplace Bertie County North Carolina (town, county, and state)

10. Usual Occupation Merchant Marine

11. Industry or business

FATHER 12. Name James R. Bazemore
13. Birthplace North Carolina

MOTHER 14. Maiden Name Mary J. Peele
15. Birthplace North Carolina

16 (a) Informant Elmo Kirkland
(b) Address Askokie, North Carolina

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3-15-47 (month) (day) (year)
(c) Cemetery or crematory Aulander
Location Aulander North Carolina

18 (a) Funeral director Wm. Cook Inc.
(b) Address 1017 E. Paul St.

19 (a) MAR 15 1947 (Date rec'd by registrar) (b) Hunting for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-13- 1947, at 3 15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull
Subarachnoid hemorrhage of brain.
Due to Lacerations of face.
Fractures of facial bones.
Other Conditions Fracture of [illegible] femur.
Cirrhosis of liver.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/13/47 3 P.M.
(b) Where did injury occur? Pier #6, Pratt St
(c) Did injury occur at home, on farm, industrial place, in public place? On Ship While at work? Yes
(d) Means of injury Fell from scaffold onto barge

23. Signature [illegible] G. Merrill M.D. Medical Examiner.
Date signed 3-14-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G49634

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered G49634

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 513 Park Ave.
(c) Hospital or institution:
11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Ba timore
(If outside city or town limits, write RURAL and give town)
2
(d) Street No. 513 Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sophia J. Simmons,

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Everette Simmons,
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 21, 1880

8. AGE: Years	Months	Days	If less than one day
67	1	23	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife,
11. Industry or business at home

FATHER
12. Name Henry Faber,
13. Birthplace Germany,

MOTHER
14. Maiden Name Elizabeth Kern,
15. Birthplace Germany,

16 (a) Informant Mr. Everette Simmons,
(b) Address 513 Park Ave.

17 (a) Burial, (Burial, cremation, or removal) (b) Date thereof 3/17/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park,
Location Baltimore City.

18 (a) Funeral director L. Vernon Lemmons.
(b) Address 4611 Park Heights Ave.

19 (a) MAR 15 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH Mar. 14, 1947 19 , at 4. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 19 47 to 3/14 1947, and that I last saw her alive on 3/13 1947

Immediate cause of death	Duration
Hypertensive Chronic Vascular disease	1 Yr
Due to	
Due to	
Other Conditions Uremia	2 wks.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alberta H Cate M. D.
Address 2675 Wilkins Ave. Date signed 3/14/47

V S 150

X

G49635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. G49635

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be answered. Physicians: please write the cause of death clearly and legibly. Give correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4801 Cordelia Ave
(c) Hospital or institution: 27 + 18

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 4801 Cordelia Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida SOPHIA SLACK

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Francis M. Slack
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 7, 1866

8. AGE: Years 81 | Months 2 | Days 5 | If less than one day hr. min.

9. Birthplace Freeland Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Christian Noll
13. Birthplace Germay

MOTHER
14. Maiden Name Elizabeth Finney
15. Birthplace Glenrock Pa

16 (a) Informant John R. Slack
(b) Address 4801 Cordelia Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/15/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location

18 (a) Funeral director C. Vernon Lomax
(b) Address 4611 Park Heights Ave

19 (a) MAR 15 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1947, at 6 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1 1947 to March 1947, and that I last saw h[illegible] alive on Mar. 12 1947.

	Duration
Immediate cause of death Myocarditis Chronic	1 yr.
Due to Broncho-Pneumonia	3 weeks
Due to	
Other Conditions arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Theresa Wentz M. D.
Address 2601 Montebello Date signed 3/12/47

G49636

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

G49636 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To the causes of death clearly and legibly. correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2912 Miles Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-7
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2912 Miles Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary L Neal
3 (b) If veteran, name war —
3 (c) Social Security Account No.

4 Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband ~~or wife~~: Thomas R Neal
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 27. 1884

8. AGE: Years 62 | Months 4 | Days 17 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation House work

11. Industry or business

FATHER 12. Name James Donnan
13. Birthplace Ireland

MOTHER 14. Maiden Name Elizabeth Lane
15. Birthplace Unknown

16 (a) Informant Thomas R Neal
(b) Address 2912 Miles Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-17-47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Md

18 (a) Funeral director Frank H Lacy
(b) Address 214 N 36 St.

19 (a) MAR 15 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/14 1947, at 10:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/26 1946 to 3/17 1947.
and that I last saw her alive on 3/3 1947.

Immediate cause of death Carcinoma of stomach with metastases to liver — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 2/20/46
Major findings of operation: Carcinoma of stomach
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm B Scale M.D.
Address 514 Medical Arts Date signed 3/14/47

VS 150

X

G49637

Birth Certificate #3.7301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G49637

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs. 30 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 342 E 25th St. Zone 18
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Mulligan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/13/47

8. AGE: Years | Months | Days | If less than one day: 4 hr. 30 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edwin D Mulligan
13. Birthplace

MOTHER
14. Maiden Name Gertrude George
15. Birthplace Baltimore

16 (a) Informant MR. EDWIN MULLIGAN
(b) Address 342 E. 25TH ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-15-47 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location CITY

18 (a) Funeral director WIEDEFELD & SON
(b) Address GREENMOUNT AVE & 22ND ST

19 (Date rec'd) MAR 15 1947 (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/13/47 19... at 10:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/13 1947 to 3/13 1947 and that I last saw her alive on 3/13 1947

Immediate cause of death Bilateral Pulmonary Atelectasis

Due to Prematurity

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide at M
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D.P. Bruickshank M. D.
Address Mercy Hospital Date signed 3/14/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

G49638

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G49638

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Where not correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 337 East 22nd St.
(c) Hospital or institution:

12-4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 337 East 22nd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MICHAEL McCLOSKEY

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1862

8. AGE: Years	Months	Days	If less than one day
85			hr. min.

9. Birthplace Ireland
(Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business

FATHER
12. Name John McCloskey
13. Birthplace Ireland

MOTHER
14. Maiden Name Anna May
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Helen McCloskey
(b) Address 337 East 22nd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral City
Location

18 (a) Funeral director WIEDEFELD AND SON
(b) Address GREENMOUNT AVE & 22ND

MAR 15 1947 (Date received by local registrar) (b) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/14/47 19 at 1045 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/8 19 47 to 3/14 19 47.
and that I last saw h alive on 3/13 19 47.

Immediate cause of death	Duration
Myocardial Insufficiency	2 hrs
Due to Chronic Nephritis	3 yrs
Due to Generalized Cerebrovascular	10 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature
Address 522 E 22 St. Date signed 3/14/47 (M. D.)

VS 150

G49639
510492

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

157E

Registered No. G49639

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not use abbreviations. Write the full name of the city or town. Do not write the words "Do not know" if the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County
(c) City or town East Bangor (If outside city or town limits, write RURAL and give town)
(d) Street No. Stewart St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Paul Conn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-2-28

8. AGE: Years 18 | Months 5 | Days 13 | If less than one day hr. min.

9. Birthplace Pa (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name William Conn
13. Birthplace Pa

MOTHER 14. Maiden Name Edith Latar
15. Birthplace Pa

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) 3/18/47 (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory East Bangor
Location East Bangor Pa.

18 (a) Funeral director John O Mostoll + sons
(b) Address 1900 Eutaw Place

19 (a) (b) Registrar
(Date received by Registrar) MAR 18 1947
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 15 1947 at 8:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 22 1947 to Mar. 15 1947 and that I last saw h[illegible] alive on Mar 15 1947

Immediate cause of death: Cardiac Failure — Duration: HOURS
Due to: CONGENITAL HEART DISEASE [CYANOTIC SINCE BIRTH] — LIFETIME (18 YRS)
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marshall Williams M. D.
Address Johns Hopkins Hospital Date signed 3-15-47

G49640

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G49640

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Caton Avenue
(c) Hospital or institution: JENKINS MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr. 3 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1536 E. Caroline Street
(If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country

3 (a) FULL NAME John T. Hart

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7, 1873

8. AGE: Years	Months	Days	If less than one day
73	9	5 7	-- hr. -- min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Marble & Tile Setter

FATHER
12. Name Patrick Hart
13. Birthplace Ireland

MOTHER
14. Maiden Name Rose Craven
15. Birthplace Ireland

16 (a) Informant Rev. John J. Hart
(b) Address 1205 N. Luzerne Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director W. C. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) MAR 15 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 19 47 at 2:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death	Duration
Acute Cardiac Dilatation	
Due to Arteriosclerotic Heart Disease	
Due to	
Other Conditions Pulmonary Fibrosis (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry W. Dalby M. D.
Address St. Agnes Hosp. Date signed 3-14-47

VS 150

G49641

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G49641

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Hennison St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2117 Hennison St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward Gross

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 22 - 1871

8. AGE: Years	Months	Days	If less than one day
75	2	20 23	hr. min.

9. Birthplace Baltimore, Md (Town, county, and State)
10. Usual Occupation Cat Cemetery
11. Industry or business Self -

FATHER
12. Name August Gross
13. Birthplace Germany -

MOTHER
14. Maiden Name Emely Pothment
15. Birthplace Unknown

16 (a) Informant Carl Gross
(b) Address 3913 Wilson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/47 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location

18 (a) Funeral director Charles P Gorsuch
(b) Address 2427 Edmondson Ave

19 MAR 15 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 14 1947, at 2:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 26 1946, to March 14 1947, and that I last saw h[illegible] alive on March 14 19 47

Immediate cause of death Cerebral Hemorrhage — Duration 3½ mos.
Due to Hypertension. — ?
Due to -
Other Conditions -

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: -
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide -
(b) Date of occurrence - at M
(c) Where did injury occur? - (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? - While at work? (Specify type of place)
(e) Means of injury -

23. Signature Wm. B. Schreeter M. D.
Address 54 S. Fulton Ave Date signed 3-15-47

X

L.L. Jacobs
1700 Eutaw

G49642

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G49642

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution: 26

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3215 Fleet st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William W. Weitzel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~ Widowed

6 (b) Name of ~~husband~~ or wife Anna M. Weitzel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15 1867

8. AGE: Years	Months	Days	If less than one day
79	10	3	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Henry Weitzel
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Wm G. Weitzell
(b) Address 3215 Fleet St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/47 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Oak Lawn
Location Eastern Ave. Extended

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St

19 (a) 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14th 1947, at 5 ~~or~~ P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1945, to March 14 1947 and that I last saw him alive on March 14 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Adv. Atherosclerosis	
Due to	
Other Conditions Adv. Bronchitis, Chr. Nephritis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis Jacobs M. D.
Address 1700 Eutaw Pl Date signed 3-14-47

VS 150

83a

G49643 BC# G 70445 BALTIMORE CITY HEALTH DEPARTMENT ✓ G49643

CERTIFICATE OF DEATH 106a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 906 Granby st.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Frank E. Crawford

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb 8th 1947

8. AGE: Years	Months	Days	If less than one day
	1	7	.....hr. .....min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation.....
11. Industry or business.....

FATHER
12. Name Ernest S. Crawford
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Jennie Carullo
15. Birthplace N. Y.

16 (a) Informant Ernest S. Crawford
(b) Address 906 Granby St.

17 (a) Burial (b) Date thereof 3/17/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Marys
Location Hampden

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a)..... (b).....
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-15 1947 at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-14 1947 to 3-15 1947, and that I last saw him alive on 3-15 1947.

Immediate cause of death	Duration
Respiratory paralysis	
Due to Laryngo-tracheo-bronchitis	
Due to acute	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature C. Nicholas Jr. M. D.
Address Univ. Hosp. Date signed 3-15-47

Huntington Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49644

BALTIMORE CITY HEALTH DEPARTMENT ✓ G49644
Registered No.

CERTIFICATE OF DEATH 46B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3117 Brendan Avenue
(c) Hospital or institution: ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 314 N. Hilton Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELMER C. ROOF

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-10-9389A

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	widowed

6 (b) Name of husband or wife Mary C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11, 1880

8. AGE: Years	Months	Days	If less than one day
66	10	3	hr. min.

9. Birthplace Green Sprin Furnace, Maryland (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Elliott Machine Corp.

FATHER
12. Name Samuel Roof
13. Birthplace Edgemont, Maryland

MOTHER
14. Maiden Name Cassandra Weddell
15. Birthplace Edgemont, Maryland

16 (a) Informant Mrs. Margaret Ritchie
(b) Address 3117 Brendan Avenue - 13

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) Thurlington Williams, M.D. Registrar
(Date rec'd by registrar) MAR 16 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 14 1947, at 1:52 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1947 to Mar 14 1947 and that I last saw him alive on Mar 13 1947

Immediate cause of death
(a) Uremia Carcinoma of Stomach
Due to
(b)
Due to
(c)
Other Conditions

Duration
about 1 yr.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L B Stevens M.D.
Address 3400 Erdman Ave Date signed 3/14/47

X

G49645

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G49645 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Glyndon Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 223 E. Lafayette Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LULA MAY BEAVERS

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Rodney T.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1885 95

8. AGE: Years	Months	Days	If less than one day
51	2	20 21	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Smith
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mary M. O'Hare
15. Birthplace Ireland

16 (a) Informant Rodney T. Beavers
(b) Address 223 E. Lafayette Avenue

17 (a) Burial (b) Date thereof 3/17/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) (b)
(Date received by local registrar) Clayton Williams, Registrar

MAR 16 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1947, at 4:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 27 1947 to Mar 14 1947, and that I last saw h[illegible] alive on March 14 1947

Immediate cause of death	Duration
Acute Myocarditis	2 days
Due to Cerebral thrombosis, left	6 months
Due to Hypertension Cardio Vascular Disease	12 yrs
Other Conditions Arthritis	20 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John P. Ulrich Jr.
Address 1227 Wash Blvd Date signed M D 3/14/47

G49646 G49673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

(G49646) Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 29 E. Wheeling St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 29 E. Wheeling St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Veronica Schroepfer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Knepp
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) 2/17/1864

8. AGE: Years 83 | Months - | Days 24 | If less than one day ... hr. ... min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Miss Ottilia Schroepfer
(b) Address 29 E. Wheeling St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location Frederick Ave

18 (a) Funeral director John F. Denny Inc
(b) Address 415 Light St.

19 (a) ... (Date rec'd by registrar) (b) ... Registrar

MAR 17 1947 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1947, at 1 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/6/1947 to 3/12/1947 and that I last saw h.. alive on 3/12/1947.

Immediate cause of death	Duration
Chronic myocarditis (with Coronary Failure)	
Due to	
Due to	
Other Conditions (1) Bronchial Asthma Chronic (2) Hemiplegia - Rt. side. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. L. Friedman M.D.
Address 1319 Light St. Date signed 3/15/47

X

G49647

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G49647 Registered No. 933

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) -

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County -
(c) City or town 3424 Old York Rd.
(If outside city or town limits, write RURAL and give town)
(d) Street No. City 18 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME OSCAR LEE SINCLAIR

3 (b) If veteran, name war -
3 (c) Social Security Account No. -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Sarah Elizabeth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/3/1873

8. AGE: Years	Months	Days	If less than one day
74	2	12	hr. min.

9. Birthplace MD. (Town, county, and state)
10. Usual Occupation -
11. Industry or business -

FATHER
12. Name Elias Sinclair
13. Birthplace MD

MOTHER
14. Maiden Name Virginia Bell
15. Birthplace MD

16 (a) Informant Chas. A. Sinclair
(b) Address 4734 Old York Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/18/47 (month) (day) (year)
(c) Cemetery or crematory Presbyterian
Location Govans

18 (a) Funeral director William Cook, Inc.
(b) Address 127 St. Paul St.

19 (a) (Date rec'd by registrar) (b) Registrar

1947 50

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/14 1947, at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/12 1947, to 3/14 1947, and that I last saw h alive on 3/14 1947.

Immediate cause of death	Duration
Asphyxia	
Fall	
Due to pulmonary embolism	
Due to arteriosclerotic heart disease.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Pulmonary Edema.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert J. Mays M. D.
Address Union Memorial Hosp. Date signed 3/14/47

X

G49648

AB-70266

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 G49648 File No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5yrs-3mos-14days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Darius King Jackson, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Nellie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30- 1875

8. AGE: Years	Months	Days	If less than one day
71	9	15 16	hr. min.

9. Birthplace Maryland (Balto)
(Town, county, and state)
10. Usual Occupation Retired Ship Builder
11. Industry or business Balto. Drydocks

FATHER
12. Name Zachariah Jackson
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Ellen Jorgenson
15. Birthplace Virginia

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/19/47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A. A. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) MAR 18 1947 (b)
(Date received by registrar) Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15- 1947, at 3.45PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-1- 1941 to 3-15 1947 and that I last saw him alive on 3-15 1947.

Immediate cause of death	Duration
Coronary Occlusion	1 day
Due to Arteriosclerotic Heart Disease	yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. E. Robinson Jr. M.D.
Address Balt City Hosp Date signed 3/15/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49649

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G49649

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Corner of Redwood & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 406 N. Greene St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Pete Monokos (PETER MOSKOS)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of ~~husband~~ wife: AMORFIA MOSKOS

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) about 1875

8. AGE: Years: About 72 | Months | Days | If less than one day: hr. min.

9. Birthplace: Greece (Town, county, and state)

10. Usual Occupation: Candy Maker

11. Industry or business: Geo. Menos

FATHER
12. Name: Unknown Moskos
13. Birthplace: Greece

MOTHER
14. Maiden Name: "
15. Birthplace: "

16 (a) Informant: Anonew Alexandrio
(b) Address: 611 E. Fort Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/18/47 (month) (day) (year)
(c) Cemetery or crematory: Greek Orthodox
Location: Balto. Co. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 127 St. Paul St.

19 (a) (Signature of registrar) (b) Huntington Williams M.D. Registrar

MAR 16 1947
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14, 1947, at 3:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 10, 1947 to March 14 1947, and that I last saw him alive on March 14 1947.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Generalized Arterio-Sclerosis	
Due to	
Other Conditions Bilateral Bronchio-pneumonia, Intestinal Obstruction (Include pregnancy within 3 months of death)	

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]
Address University Hospital Date signed 3-14-47 M. D.

X

G49650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G49650 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~3100 Auchentoroly Ter.~~
(c) Hospital or institution: Monument St
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Bala (If outside city or town limits, write RURAL and give town)
(d) Street No. 3100 Auchentoroly Ter. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LENA RUBENSTEIN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife JOSEPH

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 66 | Months | Days | If less than one day hr. min.

9. Birthplace POLAND (Town, county, and state)

10. Usual Occupation HOUSE WORK

11. Industry or business

FATHER 12. Name HENDEL

13. Birthplace POLAND

MOTHER 14. Maiden Name SARAH

15. Birthplace POLAND

16 (a) Informant HUSBAND

(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3-16-47 (month) (day) (year)

(c) Cemetery or crematory Mt Carmel

Location Herman Hill Rd.

18 (a) Funeral director Jack Levin Inc

(b) Address 1439 E. Balto St.

MAR 16 1947 (a) Junction Nicholas, Md. Registrar
(Date rec'd by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1947, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 15 1947, to March 16 1947, and that I last saw him alive on March 15 1947.

	Duration
Immediate cause of death Cardiac Failure	
Pulmonary Embolism (?)	
Due to Arterio Sclerosis & Diabetes	
Cardiac Hypertrophy & Nephritis	
Due to Pneumonia	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leon Rosenbaum M. D.

Address Sinai Hosp. Date signed 3/16/47

X

G49651

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G49651 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2100 Rutter St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2100 Rutter St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Moeka Krichinsky

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Zak

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1860

8. AGE: Years 87 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Wevel
13. Birthplace Russia

MOTHER
14. Maiden Name Ada
15. Birthplace Russia

16 (a) Informant Morris Krichinsky
(b) Address 3914 Bonner Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-16-47 (month) (day) (year)

(c) Cemetery or crematory Hebrew Mt Carmel
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 1414 E Balto St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16, 1947, at 2:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1, 1947 to March 15 1947. and that I last saw h[illegible] alive on March 15 1947.

Immediate cause of death	Duration
Cardiac Decompensation	2 wks
Due to Arteriosclerotic Cardiovascular disease	5 yrs.
Due to Senility	5 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Israel P. Marinsky M. D.
Address 910 W. North Ave Date signed March 19 47

VS 150 1947

X

G49652

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G49652

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Monument St

(c) Hospital or institution: Sinai

(d) Length of stay in hospital or inst. (yrs., mos., or days): 7

(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md (b) County:

(c) City or town: Balto (If outside city or town limits, write RURAL and give town)

(d) Street No.: Below Home for Aged (If rural give location)

(e) Citizen of foreign country?: (Yes or No)

If yes, name country:

3 (a) FULL NAME: Rebecca Cohen

3 (b) If veteran, name war: —

3 (c) Social Security Account No.: —

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife: Wallerstein

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1877

8. AGE: Years: 70 Months: Days: If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: none

11. Industry or business:

FATHER — 12. Name: Harry

13. Birthplace: Russia

MOTHER — 14. Maiden Name: Bessie

15. Birthplace: Russia

16 (a) Informant: Next Friend

(b) Address:

17 (a): Burial (Burial, cremation, or removal) (b) Date thereof: 3-16-47 (month) (day) (year)

(c) Cemetery or crematory: Herring Run

Location: Phila. Rd

18 (a) Funeral director: Jas. Lewis Inc

(b) Address: 1439 E. Baltimore St

19 (a): MAR 16 1947 (Date received by registrar) (b): Arthur Williams Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 14, 1947; at 11:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 13 1947 to March 14 1947, and that I last saw h/her alive on March 14 1947

Immediate cause of death: Myocardial Failure — Duration:

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide:

(b) Date of occurrence: at M

(c) Where did injury occur?: (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?: While at work?: (Specify type of place)

(e) Means of injury:

23. Signature: Samuel D. Daly M.D.

Address: Sinai Hospital Date signed: 3-14-47

X

G49653

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

G49653 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address BELVEDERE AVE
(c) Hospital or institution: AGED HOME 3

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1417 E. BALTO. ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ISAAC BRESSLER

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife CELIA
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years	Months	Days	If less than one day
76			hr. min.

9. Birthplace RUSSIA (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name LOUIS
13. Birthplace RUSSIA

MOTHER
14. Maiden Name FRIEDA
15. Birthplace RUSSIA

16 (a) Informant ALBERT BRESSLER
(b) Address 1605 GWYNNS FALLS Pkwy

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3-16-47 (month) (day) (year)
(c) Cemetery or crematory MT. CARMEL
Location GERMAN HILL RD

18 (a) Funeral director JACK LEWIS INC
(b) Address 1439 E. BALTO. ST.

19 (a) (b) (Date received by registrar) Hastings for Williams Registrar

MAR 10 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1947, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-13 1947 to 3-13 1947 and that I last saw h[illegible] alive on 3-13 1947

Immediate cause of death Carcinoma of oesophagus. — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edmund Levin D
Address Lewindale Date signed 3/13/47

X

G49654

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G49654 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3315 Alto Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3315 Alto Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Halbert

3 (b) If veteran, name war
3 (c) Social Security Account No. 2 [illegible] 6554

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Jennie
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1878
8. AGE: Years 69 Months Days If less than one day hr. min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name Mayer
13. Birthplace Russia

MOTHER
14. Maiden Name Pearl
15. Birthplace Russia

16 (a) Informant Jennie Halbert
(b) Address 3315 Alto Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-16-47 (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh
Location Windsor Mill Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 1409 E Balto St

19 (a) (Date received by Registrar) (b) for Williams, M.D. Registrar

MAR 16 1947
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-14-1947 at 8:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-9 1947, to 3-14 1947, and that I last saw him alive on 3-14 1947

Immediate cause of death	Duration
Coronary Throm Bosis	1 WK.
Due to Hypertension C.V. Disease	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. W. Jacobson M. D.
Address 2310 Eutaw Place Date signed 3-15-47

X

G49655

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161

G49655
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3620 Glen Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3620 Glen Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Belle Cohen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	M

6 (b) Name of husband or wife Rev. Louis J. Cohen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years	Months	Days	If less than one day
79			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name [illegible]
13. Birthplace Russia

MOTHER
14. Maiden Name [illegible]
15. Birthplace Russia

16 (a) Informant Husband
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-16-47 (month) (day) (year)
(c) Cemetery or crematory Adas Israel
Location North Capitol Rd

18 (a) Funeral director Jack Levin Inc
(b) Address 2100 Eastern Ave.

19 (a) 3-16-1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1947, at 1:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 20, 1947, to Mar 15 1947, and that I last saw her alive on Mar 15 1947.

Immediate cause of death	Duration
Heart Failure	
Due to Cerebral Embolism	one week
Due to Coronary Thrombosis	
Other Conditions Bronchopneumonia dod. Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel A. Tenenbaum M. D.
Address 3431 Park Hts Ave Date signed March 15 1947

VS 150 Transcription Williams, M.

94a

G49656

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 148 B

G49656 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Dennison St.
(c) Hospital or institution: Crawford Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1324 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Emma E. Bush.

3 (b) If veteran, name war /
3 (c) Social Security Account No. 217-07-9140

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Turbitt E. Bush
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) July 29, 1887

8. AGE: Years 59 | Months 7 | Days 14 | If less than one day: hr. min.

9. Birthplace: Baltimore Md.
(Town, county, and state)

10. Usual Occupation: Milliner.
11. Industry or business: Fashion Millinery

FATHER
12. Name: George H. Wambach
13. Birthplace: Balto. Md.

MOTHER
14. Maiden Name: Sophia Goetz
15. Birthplace: Balto. Md

16 (a) Informant: George H. Bush
(b) Address: 604 Caryobrook Rd-Pikesville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Mar 17, 1947 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: City

18 (a) Funeral director: Mr. Mrs. John H. Fenstermaker & Son
(b) Address: 5311 Edmondson Ave

19 (a) MAR 16 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 14 1947 at 2:38 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 13 1947 to Mar 14 1947.
and that I last saw h[er] alive on Mar 14 1947.

Immediate cause of death	Duration
Pulmonary Embolism	Inst.
Due to: Carcinoma uterus	
Due to: Cerebral Hemorrhage	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: H. Bleed
Address: 3814 W. North Ave. Date signed: 3/16/47 M.D.

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

G49657

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 131a

G49657
Registered No.

PLEASE WRITE PLAINLY. WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Highlands (If outside city or town limits, write RURAL and give town)
(d) Street No. 4327 Annapolis Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Krecher

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No. 212-03-7102

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edith Kreeker

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) June 8, 1894

8. AGE: Years 52 | Months 9 | Days 6 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Wentzel Paper Co. Balto.

FATHER
12. Name Frank Krecher
13. Birthplace Prague, Czechoslovakia

MOTHER
14. Maiden Name Julia Seidle
15. Birthplace Prague, Czechoslovakia

16 (a) Informant Mrs. Edith Krecher
(b) Address 4327 Annapolis Rd. Balto. Highlands

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 17, 47 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie, Md.

18 (a) Funeral director Thomas O. Singleton
(b) Address Glen Burnie, Md.

19 (a) 3/16/47 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1947 at 1:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 12 1947 to March 14 1947, and that I last saw h[illegible] alive on March 14 1947

Immediate cause of death	Duration
Uremia	
Due to Chronic Nephritis	
Due to Cardiovascular Renal Disease	One year
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address [illegible] Date signed 14 March 47

M. D.

VS 150

G49658

BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G49658

CERTIFICATE OF DEATH 1108

G49658

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Linden Ave & Madeira St.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Dorchester
(c) City or town Cambridge (If outside city or town limits, write RURAL and give town)
(d) Street No. 2 William St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME: T. Lee Le Compte

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced:
M	W	Widowed

6 (b) Name of husband or wife:

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 18, 1874

8. AGE: Years	Months	Days	If less than one day
72	5	29	hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Merchant.

11. Industry or business:

FATHER
12. Name: Francis A Le Compte
13. Birthplace: Salem, Maryland

MOTHER
14. Maiden Name: Evelyn B Foxwell
15. Birthplace: Baltimore, Maryland

16 (a) Informant: Granville Le Compte
(b) Address: Cambridge Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch 18/47 (month) (day) (year)

(c) Cemetery or crematory
Location: Cambridge, Md.

18 (a) Funeral director: John D. Mitchell & Sons
(b) Address: 1900 Eastern Place

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 16 1947
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1947, at 4:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 12 1947, to March 16 1947, and that I last saw h[illegible] alive on March 15 1947.

Immediate cause of death	Duration
Cardiac failure	
Due to Coronary Thrombosis	
Due to	
Other Conditions Lobar pneumonia	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide at M
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Edward Burkhart M.D.
Address: Md. Med. Hosp. Date signed 3/16

Registrar: Wellington Williams, M.D.

94a

G49659

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G49659
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street city
(c) Hospital or institution: Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 yrs 10
(e) Length of stay in Baltimore (yrs., mos., or days) 86 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mary Catherine Whitty

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7 February 1861

8. AGE: Years: 86 | Months: 1 | Days: 7 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business

FATHER
12. Name John Whitty
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Catherine Brawn
15. Birthplace Baltimore Md.

16 (a) Informant Sisters of the Poor
(b) Address 1200 Valley Street city

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 17, 1947 (month) (day) (year)
(c) Cemetery or crematory St Peters
Location Baltimore

18 (a) Funeral director Rita Weedefeld
(b) Address 900 East Biddle St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Mch-14- 1947, at 8 25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec-10 1946 to Mch 14- 1947, and that I last saw her alive on Mch-14 1947.

Immediate cause of death	Duration
Edema Lungs -	1 day -
Due to Chronic myacarditis	5 yrs
Due to	
Other Conditions Arterio-Sclerosis	10 yrs

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1631 E North av Date signed 3/15/47

X

G49660

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G49660
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cooperation is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 37 E. Hamburg St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 37 E. Hamburg St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Di Blasi

3 (b) If veteran, name war: none
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: late Concetta
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec. 9 1866
8. AGE: Years 80 | Months 3 | Days 6 | If less than one day hr. min.
9. Birthplace Valguarnera Caropepe Italy
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Salvatore Di Blasi
13. Birthplace Italy

MOTHER
14. Maiden Name Maria
15. Birthplace Italy

16 (a) Informant Samuel Di Blasi (Son)
(b) Address 37 E. Hamburg St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 17 1940 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

MAR 16 1940

19 (a) (Date rec'd by registrar) (b) Huntington W. Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1940, at 5:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 1940 to March 15 1940 and that I last saw h[illegible] alive on March 15 1940.

	Duration
Immediate cause of death: Cerebral Hemorrhage	1 hour
Due to: Arteriosclerosis	indef
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul L. Dampbell M. D.
Address 164 E. Lanvale St. Date signed

X

G49661

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G49661 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 DAY
(e) Length of stay in Baltimore (yrs., mos., or days) 45 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2504 MACE ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELIZABETH BEASLEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	BLACK	MARRIED

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 12, 1901

8. AGE: Years	Months	Days	If less than one day
45	9	2	hr. min.

9. Birthplace MD. (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name WILLIAM COATES
13. Birthplace [redacted] MD.

MOTHER
14. Maiden Name ALTHEA JOHNSON
15. Birthplace MD.

16 (a) Informant RECORDS
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch. 17/47 (month) (day) (year)
(c) Cemetery or crematory [redacted]
Location St. Johns Cem. Calvert Co. Md
18 (a) Funeral director Mrs. R. H. A. Elliott Dept.
(b) Address 1129 N. Carrollton St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 14 1947, at 7:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from MARCH 13 1947 to MARCH 14 1947 and that I last saw h.E.R alive on MARCH 14 1947

Immediate cause of death	Duration
(a) Cardiac failure	4 hrs.
Due to (b) Hypertensive cardiovascular disease	Not known
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
Autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [redacted] M. D.
Address Johns Hopkins Hosp. Date signed 3/18/47

VS 190

G19662

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √83a

Registered No. G49662

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton + Wilkens ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto. Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 121 Rosewood ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) √
If yes, name country

3 (a) FULL NAME Elizabeth Albert

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-10-1876

8. AGE: Years	Months	Days	If less than one day
70	4	4	hr. min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Henry Albert (decd)
13. Birthplace Pa.

MOTHER
14. Maiden Name Lennie Nichols
15. Birthplace Pa. decd

16 (a) Informant Mrs Edith A. France
(b) Address 121 Rosewood Ave - 28 -

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-19-47 (month) (day) (year)
(c) Cemetery or crematory Family Lot
Location Clearfield - Pa.

18 (a) Funeral director Edw. S. MacNabb
(b) Address Frederick & Edmondson Ave Catonsville - Maryland

19 (a) MAR 17 1947 (Date rec'd by registrar) Registrar
(b)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-14-47 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-6 1947 to 3-14 1947, and that I last saw h[illegible] alive on 3-14 1947

Immediate cause of death Bronchopneumonia — Duration Weeks

Due to — Duration

Due to — Duration

Other Conditions Cerebral Hemorrhage — Duration 9 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward H. Phillips M. D.
Address 1 Highland Ave. Catonsville Md. Date signed 3-14-47

107

G49663

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G49663

1108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 509 S. Hanover st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Queen Annes
(c) City or town Grasonville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rural
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dolores C. Eaton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband Walter M. Eaton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 9th 1866

8. AGE: Years	Months	Days	If less than one day
80	6	6	hr. min.

9. Birthplace Queen Annes Co. Md.
(Town, county, and state)
10. Usual Occupation Honor wife
11. Industry or business Own Home

FATHER
12. Name Samuel Hampton
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Haddaway
15. Birthplace Md.

16 (a) Informant Miss Dolores Eaton
(b) Address 1203 Cathedral st.

17 (a) Burial (b) Date thereof 3/18/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Peters
Location Queenstown Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st.

19 (a) MAR 17 1947 (b) Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 15th 1947, at 8:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 13 1947 to Mar 15 1947 and that I last saw h[illegible] alive on March 15 1947

Immediate cause of death	Duration
Lobar Pneumonia (Bilateral)	3 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. J. Barranco

Address 4368 Fort Ave Date signed 3/16/47

X

49664 Birth Certificate B-73555

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

G49664
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Redwood
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balt 24 (If outside city or town limits, write RURAL and give town)
(d) Street No. 323 Cornwall St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country NO

3 (a) FULL NAME Baby Boy Fraser

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife: None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9300 a 3/14/47

8. AGE: Years	Months	Days	If less than one day
0	0	0	15 hr. 15 min.

9. Birthplace Baltimore, MD (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Clemens J Fraser
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Stein
15. Birthplace Maryland

16 (a) Informant Mary Fraser
(b) Address 323 Cornwall St Balt

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/18/47 (month) (day) (year)
(c) Cemetery or crematory Loh Lorraine
Location Baltimore MD

18 (a) Funeral director Williams & Co
(b) Address 1217 E Pratt St

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 17 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/15 1947, at 3:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 3/15 1947, and that I last saw him alive on 3/15 1947.

Immediate cause of death: Congenital Atelectasis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John M Eggleston M. D.
Address Univ Hosp Date signed 3/16/47

X

G49665 BCH E56890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

80B

Registered No. G49665

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Union Memorial Hospital
(c) Hospital or institution: 33rd & Calvert Sts

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 209 W Read St. Balt-2 (If rural give location) Md
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Chan (FLORENCE CHAN)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female | 5 Color or race: Chinese | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 17, 1946

8. AGE: Years 0 | Months 5 | Days 28 | If less than one day hr. min.

9. Birthplace Balt. Md
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Manuel E Chan
13. Birthplace China

MOTHER
14. Maiden Name Mary Jenwa
15. Birthplace China

16 (a) Informant Parent
(b) Address 209 W. Read St. Balt-2

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-17-47 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn

18 (a) Funeral director Stewart Memorial
(b) Address 1080 Linden Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Will Burial MH

VS 150 MAR 17 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1947 at 4:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 2 1947 to March 15 1947 and that I last saw h.e.r. alive on March 15 1947

Immediate cause of death	Duration
Pyuria	
Due to Encephalitis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. Klemstein Fuentes Jr. M. D.
Address Union Mem. Hosp. Date signed 3-15-47

G49666

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

150c

Registered No. G49666

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1da
(e) Length of stay in Baltimore (yrs., mos., or days) 1da

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balt Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 22 Dutton Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Zan Galloway (MRS ZAN HOPKINS GALLOWAY)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife F. Ross Galloway
6 (c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) June 24-1918

8. AGE: Years	Months	Days	If less than one day
28	8	20	hr. min.

9. Birthplace Md. (Relay)
(Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER 12. Name Walter Hopkins
13. Birthplace Va.

MOTHER 14. Maiden Name Hazel Herold
15. Birthplace Md.

16 (a) Informant F. R. Galloway (Husband)
(b) Address Catonsville Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-16-47 (month) (day) (year)
(c) Cemetery or crematory Bells National
Location Balto Md.

18 (a) Funeral director Stewart-Haywards
(b) Address 2108 W. North Ave

19 (a) (Date rec'd by registrar) (b) Registered No.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-16 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/5 1947 to 3/16 1947. and that I last saw h[illegible] alive on 3-16 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Etiology undetermined	
Due to	new
Other Conditions Post partum	3 hrs 10 min

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: not obtained

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert F. Lericos

Address St. Agnes Hosp. Date signed 3/16/47

X

G49667

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

Reg. G49667

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2126- Bolton Street.
(c) Hospital or institution: at her home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 24yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2126- Bolton Street.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME MINNIE M. DRISCOLL (Minnie Marie Driscoll

3 (b) If veteran, name war none
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Jos P. Driscoll
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) July 28-1901

8. AGE: Years 45 | Months 7 | Days 15 18 | If less than one day ____ hr. ____ min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation none
11. Industry or business none.

FATHER
12. Name George Maxeiner
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Stottenfeltz
15. Birthplace Germany

16 (a) Informant Jos P Driscoll (Husband)
(b) Address 2126 Bolton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-18-47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director Stewart Mortuary
(b) Address 108 W Monument St.

19 (a) 3-17-47 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15, 1947, at 1.35 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Diffuse Peritonitis

Due to Intestinal Obstruction, Ventral Hernia

Other Conditions ____
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur? ____
(c) Did injury occur at home, on farm, industrial place, in public place? ____ While at work? ____
(d) Means of injury ____

23. Signature Earl L Royer M.D.
Medical Examiner
Date signed ____

HEALTH DEPARTMENT—CITY OF BALTIMORE

G49668 CERTIFICATE OF DEATH 194a G49668

Registered No.....

1. PLACE OF DEATH 4306 Maine Ave

CITY OF BALTIMORE: (No. 4306 St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 60 yrs. 7 mos. — da. How long in U. S. If of foreign birth? ... yrs. ... mos. ... da.

2. FULL NAME Frances Robbins Kane If U. S. Veteran specify WAR No

(a) Residence: No. 4306 Maine Ave St., ... Ward. (If non-resident give city or town and State)
(Usual place of abode)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

3a. If married, widowed, or divorced: HUSBAND of (or) WIFE of Samuel Rankin Kane

6. DATE OF BIRTH (month, day, year) October 19, 1882

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
64	4	24	

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Home
10. Date deceased last worked at this occupation (month and year) 1945 11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Media, Pennsylvania

FATHER
13. NAME Edward Hyde Robbins
14. BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

MOTHER
15. MAIDEN NAME Sarah Halderman
16. BIRTHPLACE (city or town) (State or country) Pennsylvania or Maryland

17. INFORMANT Samuel Rankin Kane (Address) 4306 Maine Ave

18. BURIAL, CREMATION, OR REMOVAL Place London Park Date 3-18-47 19...

19. UNDERTAKER Stewart & Company (Address) 108 W. Mulberry St.

20. FILED ... 19... ... Registrar.

MAR 18 1947 Huntington Hall

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) March 15 1947, 1947

22. I HEREBY CERTIFY, That I attended deceased from January 23, 1945, to March 15, 1947. I last saw h... alive on March 13, 1947. Death is said to have occurred on the date stated above, at 6:20 P.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Coronary Occlusion	1/1945
Myocardial Insufficiency.	

Other contributory causes of importance:

Was an operation performed? ... Date of ...

For what disease or injury? ...

Name of operation ...

What test confirmed diagnosis? ... Was there an autopsy? ...

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? ... Date of injury ..., 19...

Where did injury occur? ...
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? ...
If so, specify ...

(Signed) W. Hopkins Hutchinson, M. D.

(Address) 214 Medical Arts Bldg

V9 8

X

G49669

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 94a

G49669 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 106 W. University Parkway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 106 W. University Pky. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Adele F. Baldwin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Loami H. Baldwin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 3, 1858

8. AGE: Years	Months	Days	If less than one day
88	7	11	hr. min.

9. Birthplace Binghampton, N. Y. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Elisha French
13. Birthplace N. Y.

MOTHER
14. Maiden Name Mary Van Denshoten
15. Birthplace N. Y.

16 (a) Informant Alice B. Stewart
(b) Address 106 W. University Pky.

17 (a) Entombment (Burial, cremation, or removal) (b) Date thereof 3/17/47 (month) (day) (year)
(c) Cemetery ~~Greenmount~~ Mausoleum
Location North & Greenmount Aves.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) (b) Huntington Williams, M.D. Registrar

MAR 17 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1947, at 4.20PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 12 1947 to March 14 1947 and that I last saw her alive on March 14 1947

Immediate cause of death: Coronary occlusion — Duration
Due to Arterio Sclerosis
Due to
Other Conditions Senility
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank A. Anderson M. D.
Address 3001 Shannon Drive Date signed 3/16/47

X

G49670

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G49670

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2621 Loyola Northway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2621 Loyola Northway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Pearl Rosenberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Lew Irving

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years 52 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Yaukel
13. Birthplace Russia

MOTHER
14. Maiden Name Zlotz
15. Birthplace Russia

16 (a) Informant Irving Rosenberg
(b) Address 2621 Loyola Northway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-17-47 (month) (day) (year)
(c) Cemetery or crematory United Hebrew
Location Washington Boulevard

18 (a) Funeral director Jack Lewis Inc
(b) Address 1434 E Balto St

19 (a) (Date filed) MAR 19 1947 (b) Signature of Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1947, at 2:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 10 1947 to Mar 17 1947 and that I last saw her alive on March 17 1947

Immediate cause of death Heart Failure — Duration 8 months

Due to Toxemia

Due to Carcinoma of the Stomach

Other Conditions Bronchopneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel V. Youngelson M. D.
Address 3720 Clarinth Rd Date signed March 17, 1947

G49671

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55a

Registration No. G49671

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2355 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALEXANDER KREMEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife SARAH

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
66			hr. min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation INSURANCE

11. Industry or business

FATHER
12. Name NOT KNOWN
13. Birthplace RUSSIA

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace RUSSIA

16 (a) Informant HOSPT. RECORDS
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3-17-47 (month) (day) (year)
(c) Cemetery or crematory MT. CARMEL
Location GERMAN HILL RD

18 (a) Funeral director Jenk Lewis Inc
(b) Address 1439 E. Balto St

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 17 1947 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1947, at 3 40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1947 to March 16 1947 and that I last saw h[e] alive on March 16 1947.

	Duration
Immediate cause of death Pulmonary edema	
Due to Arteriosclerotic cardio vasular disease	
Due to	
Other Conditions Carcinoma of adrenal cortex.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Heinz Bissinger M.D.
Address Sinai Hospital Date signed 3/16/47 M. D.

V S 150

X

G49672

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G48672

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 622 Hoven
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 12yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 622 Hoven St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pauline Shannon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1892

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace Parkersville S.C.
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Sylvia Johnson
15. Birthplace S.C.

16 (a) Informant Pearle Johnson
(b) Address 1536 W Lexington St

17 (a) Burial (b) Date thereof 3-17-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director James A Hayes
(b) Address 142 N Stricker St

19 (a) MAR 17 1947
(Date rec'd by local registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1947 at 8:58 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 9 1947 to March 13 1947.
and that I last saw her alive on March 13 1947.

Immediate cause of death	Duration
Myocarditis	6 hours
Due to	
Due to	
Other Conditions Enteritis	4 days

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W H Watts M. D.
Address 754 Arlington Ave Date signed 3/15/47

VS 150

Huntington Williams, M.D.

X

G49673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

$3a

Registered No. G49673

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Lombard
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Belair
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Richardson

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
77	—	—	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Auctioneer
11. Industry or business

FATHER
12. Name John Richardson
13. Birthplace md.

MOTHER
14. Maiden Name Mary Rose
15. Birthplace md.

16 (a) Informant D. Charles Richardson
(b) Address Belair

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 19/47 (month) (day) (year)
(c) Cemetery or crematory Abingdon
Location Abingdon Md

18 (a) Funeral director Geary & Foster
(b) Address Belair Md

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-16 1947, at 11:35 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-14 1947 to 3-16 1947 and that I last saw him alive on 3-16 1947.

Immediate cause of death Terminal Pneumonia — Duration

Due to Uremia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Brookman M. D.
Address Univ. Hosp. Date signed 3-17-47

VS 150

X

G49674

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V94a

Registered No. G49674

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 W. Cold Spring Lane
(c) Hospital or institution: Elkins Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 524 N. Decker Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna K. Harmel

3 (b) If veteran, name war ---

3 (c) Social Security Account No. ---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Wilhelm Harmel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8, 1863

8. AGE: Years	Months	Days	If less than one day
83	9	8	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Doell
13. Birthplace Maryland

MOTHER
14. Maiden Name
15. Birthplace Maryland

16 (a) Informant Henry Harmel
(b) Address 524 N. Decker Ave-5

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 19, 1947 (month) (day) (year)
(c) Cemetery or crematory Zion Cemetery
Location Stemmers Run, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.,

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 17 1947

VS 150

Huntington

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1947, at 6:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 15 1947 to March 16 1947 and that I last saw her alive on March 15 1947

Immediate cause of death	Duration
Coronary Insufficiency,	3 mo.
Due to Generalized Arteriosclerosis.	10 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman R Klemian M.D.
Address 3803 Edmondson Ave Date signed 3/17/47

X

G49675

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 166

G49675 Registered No.

Every item of information should be carefully supplied. Use ink. PLEASE WRITE PLAINLY, WITH UNFADING INK. write the causes of death clearly and legibly. correct age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 609 N. Appleton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph H Duggins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widower

6 (b) Name of husband or wife: Ruth Duggins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7, 1910

8. AGE: Years: 36 | Months: 9 | Days: 7 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: John Duggins
13. Birthplace: North Carolina

MOTHER
14. Maiden Name: Agnes Pumphrey
15. Birthplace: Essex Co. Va.

16. (a) Informant: Agnes Duggins
(b) Address: 609 N. Appleton St.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 3-18-47 (month) (day) (year)
(c) Cemetery or crematory: Arlington
Location: Balto. Co.

18 (a) Funeral director: Jesse W. Bedden
(b) Address: 436 N. Biddle St

19 (a) MAR 17 1947 (Date received by registrar) Huntington Williams M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14, 1947, at 9A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Bullet wound of Brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-14-47 at 2:30A. M.
(b) Where did injury occur? Pennsylvania Ave. & Monroe Street
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Firearms

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 3-14-47

X

G49676

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 131a

Registered No. G49676

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1514 Division St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Mahaley Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	N	M

6 (b) Name of husband or wife James Moore
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
64 63			hr. min.

9. Birthplace Cambridge, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Luke Nichols
13. Birthplace Md

MOTHER
14. Maiden Name Mary Jane
15. Birthplace Md

16 (a) Informant Mr James Moore
(b) Address 761 Vine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-17-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location Anne Arundel Co. Md

18 (a) Funeral director Mrs Frances A. Hensley
(b) Address 578 W. Biddle St

19 (a) (Date rec'd by registrar) (b) Registrar

Huntington Hillsman

MAR 17 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/14 1947, at 12 01 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/27 1947, to 3/14 1947.
and that I last saw h.r alive on 3/14 1947.

Immediate cause of death	Duration
Uremia	
Due to Hypertensive Cardio-Vas-cular Renal Disease	15-20 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James D. Carr M. D.
Address 515 Walker St Date signed 3-15-47

G49677

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G49677 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1334 N. Carey Street
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1334 North Carey Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary E. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife Thomas Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1885

8. AGE: Years	Months	Days	If less than one day
61	10		hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Albert Muse

13. Birthplace Va

MOTHER 14. Maiden Name Willis ?

15. Birthplace Va

16 (a) Informant Florence Gibson

(b) Address 1334 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-17-47 (month) (day) (year)

(c) Cemetery or crematory Pleasant Rest

Location Towson Md

18 (a) Funeral director George G. Nelson

(b) Address 1303 Pennsylvania Ave

19 (a) (b) Huntington West Virginia

(Date received by registrar) MAR 17 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14, 1947 at 5 P. M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Mueller M.D. Medical Examiner.

Date signed 3-17-47

X

G49678

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193a

Registered No. G49678

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 524 Jochenson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 524 Jochenson St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country Johannesburg

3 (a) FULL NAME Ellen Handy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife [redacted]

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1839

8. AGE: Years 108 | Months 2 | Days 10 | If less than one day ____ hr. ____ min.

9. Birthplace Prince Ann Co. Md. (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Anthony Waters
13. Birthplace Md.

MOTHER
14. Maiden Name Caroline Waters
15. Birthplace Md.

16 (a) Informant Ethel Bailey
(b) Address 524 Jochenson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/11/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Elroy A Wilson
(b) Address 1000 Brunt Ly Ave

19 (a) [redacted] (Date received by registrar) (b) [redacted] Washington Blvd (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/11 1947, at 4:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/8 1947, to 3/11 1947, and that I last saw h[illegible] alive on 3/11 1947.

Immediate cause of death Acute Myocarditis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. N. Hahn

Address 1 x 15 Pl W Date signed 3/14/47 D.

G49679 BH

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

b 43959 107

G49679
Registered No.

MARGIN ... PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 707 W. Franklin St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 707 W Franklin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Beverly Hampton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 23, 1946

8. AGE: Years	Months	Days	If less than one day
	11	21	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Frank Hampton
13. Birthplace N. C.

MOTHER
14. Maiden Name Fannie May Pitchford
15. Birthplace N. C.

16 (a) Informant Fannie M. Hampton
(b) Address 707 W. Franklin St

17 (a) Burial (b) Date thereof 3/17/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy A Wilson
(b) Address 1000 Granby Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/14/47 19 9:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-1 1947 to 3-14 1947. and that I last saw him alive on 3-13 1947.

Immediate cause of death	Duration
Bronchial Pneumonia	
Due to Acute Bronchitis.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W M Luther M.D.
Address 203 S Stricker St Date signed 3/17/47

VS 15 MAR 17 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49680

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 113

Registered G49680

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 131 Stockton St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 131 Stockton St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Noomi Barter

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan 1 - 19 - 1923

8. AGE: Years	Months	Days	If less than one day
24	2	13	hr. min.

9. Birthplace Baltimore City
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business Home

FATHER
12. Name Thomas Barter
13. Birthplace Frederick Md.

MOTHER
14. Maiden Name Addie Wade
15. Birthplace Frederick Md

16 (a) Informant Addie Barter
(b) Address 1346 N Stockton
17 (a) Burial (b) Date thereof Mar 18-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn
18 (a) Funeral director J. E. Brooks
(b) Address 1463 N. Carey St
19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/14/47 19 7:00 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 3/11/47 19 to 3/17/47 19 and that I last saw h alive on 19

Immediate cause of death	Duration
Tuberculosis Laryngitis	
Due to Pulmonary Tuberculosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Harlan Fleck M. D.
Address 924 Mad Ave Date signed 3/16/47

VS (50) MAR 17 1947 Huntington Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49681

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G49681

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Etting Street
(c) Hospital or institution: 17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1213 Etting Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Anderson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Rosetta

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1, 1884

8. AGE: Years 62 | Months 11 | Days 12 | If less than one day hr. min.

9. Birthplace Elkridge Md. (Town, county, and state)

10. Usual Occupation Dishwasher

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace Maryland

16 (a) Informant Rosetta Ella Anderson
(b) Address 1213 Etting Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-19-47 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location

18 (a) Funeral director A. Halstead
(b) Address 91 Arnold Hill Ave

19 (a) (Date rec'd by registrar) MAR 17 1947 (b) Registrar Huntington Mather

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1947 at 6.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-20 1947 to 3-13 1947 and that I last saw h.. alive on 3-13 1947

	Duration
Immediate cause of death Cerebral Hemorrhage	
Due to Arteriosclerosis	1 Yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Atwell Jones M. D.
Address 5-5-4 Dolfield Date signed 3-14-47

X

G49682

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 146B

Registered No. G49682

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 533 Orchard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 533 Orchard St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Williams

3 (b) If veteran, name war

3 (c) Social Security Account No. 250-05-7121

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	colored	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1888

8. AGE: Years	Months	Days	If less than one day
58	8	27	hr. min.

9. Birthplace Annapolis, S. C. (Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER
12. Name Jeff. Williams
13. Birthplace South Carolina

MOTHER
14. Maiden Name Sallie Edens
15. Birthplace South Carolina

16 (a) Informant Lola Williams
(b) Address 928 Druid Hill Ave

17 (a) Burial (b) Date thereof 3/17/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill Md.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 17 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1947 at 8:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 22 1947 to Mar 13 1947 and that I last saw h[illegible] alive on Mar 13 1947.

Immediate cause of death	Duration
Cancer	
Due to Stomach	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank E. Wagner M. D.
Address 3827 Eastern Ave

Huntington Williams, M.D.

G49683

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G49683
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3502 Clifton Avenue
(c) Hospital or institution: Mrs. Alice Pitterhoff private Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1408 E. Cold Spring Lane
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs. Margarete Fischer

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4 Sex Female | 5 Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Nicholas Fischer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 9. 1864

8. AGE: Years 82 | Months 4 | Days 5 | If less than one day hr. min.

9. Birthplace Bracht Germany
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John Ungemach
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Rosenfling
15. Birthplace Germany

16 (a) Informant William B. D Fischer
(b) Address 831 E. Belvedere Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 17-1947 (month) (day) (year)

(c) Cemetery or crematory Manchester
Location Carroll Co. Maryland

18 (a) Funeral director Burgee Funeral Home

(b) Address 3631 Falls Road

19 (a) MAR 17 1947 (Date filed by registrar) Huntington Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14- 1947 at 3-15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1946 to March 14 1947 and that I last saw her alive on MARCH 13 1947

	Duration
Immediate cause of death: Cerebral Hemorrhage	6 hrs
Due to Arteriosclerosis	20 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Arthur J Davies M. D.
Address 800 W 33rd St Date signed 3-15-47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49684

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G49684 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital. 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3650 Falls Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MacMurray Caltrider

3 (b) If veteran, name war —

3 (c) Social Security Account No. 218-07-6718

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29-1879

8. AGE: Years 67 | Months 9 | Days 16 | If less than one day hr. min.

9. Birthplace Hampstead Carroll Co., Md.
(City, county, and state)

10. Usual Occupation Plumber

11. Industry or business

FATHER
12. Name Jacob Caltrider
13. Birthplace Maryland

MOTHER
14. Maiden Name Anna M. Sellers
15. Birthplace Maryland

16 (a) Informant Emerson Lee Caltrider
(b) Address 1309 W 41st Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-18-1947 (month) (day) (year)

(c) Cemetery or crematory St Johns
Location Ellicott City, Md.

18 (a) Funeral director Byerly Funeral Home
(b) Address 3631 Falls Road Huntington Williams, MD

19 (a) MAR 17 1947 (Registered by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15, 1947, at 4.30 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Edema

Due to Acute Congestive Heart Failure

Other Conditions Fracture Neck Femur

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D.
Medical Examiner.
Date signed 3-17-47

VS 191

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49685

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 557

Registered G49685

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmont Ave
(c) Hospital or institution: The Church Home & Hospital W3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 185da
(e) Length of stay in Baltimore (yrs., mos., or days) 71yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1224 S. Chas. St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country —

3 (a) **FULL NAME** Mr. Henry G. Weaver

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Mrs. Catherine Weaver
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 27, 1875

8. AGE: Years	Months	Days	If less than one day
71	6 7	18	....hr. ....min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Lawyer
11. Industry or business Law

FATHER
12. Name Wm G. Weaver
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Wilhelmina Seibel
15. Birthplace Baltimore, Md.

16 (a) Informant Patient
(b) Address 1224 South Chas. St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-17-1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director Thomas J. Fleming
(b) Address 1716 Light St.

19 MAR 17 1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 March 19 47 at 12 55 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11 Sept 1946 to 14 Mar 1947 and that I last saw him alive on 14 Mar 1947.

Immediate cause of death	Duration
Pneumonia gangrenous	
Due to Meningitis	
Due to Carcinoma entrance melanoma to Brain	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: Meningitis - Carcinoma brain

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nicholas J. Fohlermann M. D.
Address Church Home & Hosp. Date signed 14 Mar 47

VS 150

~~D-19689~~ + Am. case of

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C-19686

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ...
(c) Hospital or institution: University Hospital (Dead on arrival)
(d) Length of stay in hospital or inst. (yrs., mos., or days) ...
(e) Length of stay in Baltimore (yrs., mos., or days) ...

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 324 Bank St (If rural give location)
(e) Citizen of foreign country? ... (Yes or No)
If yes, name country ...

3 (a) FULL NAME GEORGE LEMBACH

3 (b) If veteran, name war ...
3 (c) Social Security Account No. ...

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Margaret
6 (c) If dead, give age ... years

7. Birth date of deceased (mo., day, yr.) FEB 29 - 1875

8. AGE: Years	Months	Days	If less than one day
72	6	16	... hr. ... min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Coal & Wood Yard
11. Industry or business

FATHER
12. Name Theodore Lembach
13. Birthplace Balto

MOTHER
14. Maiden Name Julian
15. Birthplace Balto Md

16 (a) Informant Margaret Lembach
(b) Address 11 N. Ridgely St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/21-47 (month) (day) (year)
(c) Cemetery or crematory Balto Cem
Location North Ave

18 (a) Funeral director Edmund Fonlon
(b) Address 2213 Wash Blvd

19 (a) MAR 17 (Date rec'd by registrar) (b) 1947 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 March 1947, at 8:57 M

21. I certify that death occurred on the date above stated; that I attended deceased from (seen alive) 19... to (seen dead) 19... and that I last saw h... alive on (dying) 19...

Immediate cause of death	Duration
Coronary occlusion (Seen in office of Dr. Edward Williams & sent to University Hosp.	
Due to died en route).	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation ...
Major findings of operation: ...
of autopsy: ...

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ...
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? ...
(e) Means of injury ...

23. Signature Wm. Raley M. D.
Address Univ. Hosp. Date signed 3-17-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

Huntington Williams, M.D.

For E. R. Orrio, M. Howard J. Mohler, M.D.

G49687

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G49687.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1100 RIDGELY ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1100 Ridgely St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY E ZIEGFELD

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEM	WHITE	WIDOW

6 (b) Name of husband or wife DANIEL ZIEGFELD
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV 12 1878

8. AGE: Years	Months	Days	If less than one day
68	4	3	hr. min.

9. Birthplace BALTIMORE MD
(Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name JOHN HAMMEL
13. Birthplace BALTO MD

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace NOT KNOWN

16 (a) Informant MRS CHARLOTTE JENKINS
(b) Address 1100 RIDGELY. ST

17 (a) BURIAL (b) Date thereof MARCH 1947
(Burial, cremation, or removal) (month), (day), (year)
(c) Cemetery or crematory WESTERN CEM
Location BALTO MD

18 (a) Funeral director Bernard C Harlow
(b) Address 121 E West St

19 (a) (Filed by Registrar) MAR 17 1947 (b) Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1947 at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to March 15 1947, and that I last saw h[illegible] alive on March 11 1947

Immediate cause of death Coronary Thrombosis — Duration 5 weeks
Due to
Due to
Other Conditions Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 533 Ampt Date signed 3/18/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49688 — Registered No. G49688

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Black Caucasian — D. 23 6/13 — 157 B

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2025 West Fayette St

(c) Hospital or institution: Bon Secours Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 5

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4355 Bonner St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby boy Totaro

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	

6 (b) Name of husband or wife Antony Thomas Totaro

6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) 3/16/47

8. AGE: Years	Months	Days	If less than one day
0	0	0	hr. 15 min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Antony Thomas Totaro

13. Birthplace Philadelphia

MOTHER — 14. Maiden Name Freda Amey

15. Birthplace Baltimore

16 (a) Informant Mother

(b) Address 4355 Bonner St, Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/47 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Location Belair Rd. Balto. Md

18 (a) Funeral director Israel Dallas Sons

(b) Address 524 Mosher St

19 (a) MAR 17 1947 (Date filed with registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1947, at 2:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 16 1947 to March 16 1947 and that I last saw him alive on March 16 1947

Immediate cause of death	Duration
Respiratory failure	
Due to ?	
Due to	
Other Conditions Monstrosity - morning sickness (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Dr. William F. Love, M.D. M. D.

Address Bon Secours Hosp. Date signed 3-16-47

Washington Williams, M.D. Registrar

VS 150

X

HEALTH DEPARTMENT—CITY OF BALTIMORE

G49689 CERTIFICATE OF DEATH 43B G49689

1. PLACE OF DEATH Crawford Retreat Registered No.

CITY OF BALTIMORE: (No. 2117 Denison St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth 35 yrs. mos. ds.

2. FULL NAME John Vasicek If U. S. Veteran specify WAR

(a) Residence: No. 612 N. Chester St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	SINGLE

5a. If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6. DATE OF BIRTH (month, day, year) Nov. 2, 1876

7. AGE Years	Months	Days	If LESS than 1 day hrs. or min.
71	4	13	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. MERCHANT

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. DRY GOODS STORE

10. Date deceased last worked at this occupation (month and year) 12/40

11. Total time (years) spent in this occupation 30 YRS.

12. BIRTHPLACE (city or town) (State or country) WETENBERK GERMANY.

FATHER

13. NAME JOHN VASICEK

14. BIRTHPLACE (city or town) (State or country) CZECHOSLOVAKIA

MOTHER

15. MAIDEN NAME WILHELMINA JANACEK

16. BIRTHPLACE (city or town) (State or country) CZECHOSLOVAKIA

17. INFORMANT V. V. Jorka M. D.
(Address) 845 N. Patterson Park Ave

18. BURIAL, CREMATION, OR REMOVAL
Place Oak Hill Date 3-18-47, 19

19. UNDERTAKER Frank Leach & Son
(Address) 900 N. Gilmor St

20. FILED, 19 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) MARCH 15, 1947

22. I HEREBY CERTIFY, That I attended deceased from JAN. 1943 to MARCH 15, 1947

I last saw him alive on MARCH 15, 1947. Death is said to have occurred on the date stated above, at 5:50 P.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
CEREBRAL THROMBOSIS	1 week
ARTERIO-SCLEROSIS - GENERALIZED	?
HYPERTENSION	?

Other contributory causes of importance:

Was an operation performed? No Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
No If so, specify

(Signed) David T. Kline M. D.
(Address) 2623 E. Monument St.

V0.5

Huntington Williams, M.D.

MAR 17 1947

X

WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state EXACTLY. Every statement of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Every statement of OCCUPATION is very important. See instructions on back of certificate.

649690

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered 649690

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1368 N. Stricker St
(c) Hospital or institution: 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1368 N. Stricker St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Holly

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Ella Holly

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1881

8. AGE: Years: 65 | Months: 8 | Days | If less than one day: hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Ella Holly
(b) Address 1368 N. Stricker St

17 (a) Burial (b) Date thereof 3-17-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. E. Nelson
(b) Address 1703 Pennsylvania Ave

19 (a) MAR 17 1947 rec'd by registrar Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1947, at 9 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-1-47 to 3-14-47
and that I last saw h[illegible] alive on 3-13 1947
Immediate cause of death Acute Enteritis Collapse
Due to Chron. Cardio-Vas-Renal disease
Due to
Other Conditions senility, debility
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. N. Cardozo M. D.
Address 524 D. Hill Ave Date signed 3-17-47

VS 150

G49691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G49691

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 531 S. Bentalou St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 531 S Bentalou St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME William C. Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Cecilia C. Lee

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 21 1870

8. AGE: Years 76 | Months 11 | Days 22 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William F. Lee
13. Birthplace Maryland

MOTHER 14. Maiden Name Mary Crawford
15. Birthplace Maryland

16 (a) Informant Cecilia C. Lee
(b) Address 531 S. Bentalou St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 17 47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore - Md.

18 (a) Funeral director F. B. Wickert & Son
(b) Address 1701 Eutaw Place

19 (a) ____ (Date rec'd by registrar) (b) Huntington Williams, M.D.

V S MAR 17 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/27/47 19 ____, at ____ M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 27 19 47 to March 13 19 47 and that I last saw h. alive on March 13 19 47

Immediate cause of death Coronary Thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alfred Cole M. D.
Address 1934 Wilkens Ave Date signed 3-15-47

Dr. Alfred Cole 1934

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49692

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56c

G49692 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 da
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2633 Francis St. #17 (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes Lillian Biasi

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex: fem. | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Marian Biasi

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 28, 1898

8. AGE: Years 48 | Months 10 | Days 17 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Peter Biadunis
13. Birthplace Russia

MOTHER
14. Maiden Name Anna Steiger
15. Birthplace New York

16 (a) Informant hospital record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/19/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem. Balto., Md.
Location

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by Reg.) (b) Registrar

MAR 17 1947 Huntington Hillcrest, Md

VS 150

MEDICAL CERTIFICATION 45

20. DATE OF DEATH March 15 1947, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-1 1947 to 3-15 1947 and that I last saw h.. alive on 3-15 1947

Immediate cause of death: resp. failure

Due to: pulmonary embolism

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3-10-47

Major findings of operation: pneumectomy

of autopsy:

Duration
1

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James J. Sulak M. D.
Address Mercy Hosp Date signed 3-15-47

G49693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G49693

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3812 White Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Etta Wheeler

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widow

6 (b) Name of husband or wife Thomas C. Wheeler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17, 1880

8. AGE: Years	Months	Days	If less than one day
66	4	27	hr. min.

9. Birthplace Dorchester Co., Md.
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Butler Brothers

FATHER
12. Name Dail
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mr. Thomas F. Dail
(b) Address 115 Patapsco Ave. Dundalk 22

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/18/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.
19 (a) (Date rec'd by registrar) (b) 17 1947 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/17 1947, at 6:24 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature D. C. Schreiber M.D.
Medical Examiner.
Date signed 3/18/47

VS 181

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G49694

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 46E

Registered No. G49694

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Caton Ave.
(c) Hospital or institution: St. Agnes Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: Howard
(c) City or town: Hanover (If outside city or town limits, write RURAL and give town)
(d) Street No.: Hanover Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: CARL JERNS

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: 216-03-1727

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Catherine S. Jerns

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 11/9/1880

8. AGE: Years: 66 | Months: 4 | Days: 7 | If less than one day: hr. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual Occupation: Machinist

11. Industry or business: Davis & Hemphill

FATHER
12. Name: - Daniel Jerns
13. Birthplace: Germany

MOTHER
14. Maiden Name: Luise Mattern
15. Birthplace: - Germany

16 (a) Informant: Mrs. Geneva Purcell
(b) Address: Hanover Rd., Hanover, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 3/19/47 (month) (day) (year)
(c) Cemetery or crematory: Grace Episcopal
Location: Elkridge, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3/16/47, 19, 6:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/9/47 19 to 3/16/47 19 and that I last saw him alive on 3/16/47

Immediate cause of death: Cardiac failure - Status Asthmaticus - Diabetes Mellitus

Due to: HBP

Due to:

Other Conditions: Carcinoma of the Sigmoid

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: [illegible]

Address: [illegible] Date signed: 3/19/47

Huntington Hillen

937

G49695

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G49695

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1125 N Longwood St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 b'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto-10 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1125 N Longwood St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Benjamin John Tregoe

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 214-03-1316

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Kitty Rose Adelaide Tregoe (nee Taylor) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 26, 1885

8. AGE: Years	Months	Days	If less than one day
61	11	20	hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Cashier

11. Industry or business: Home Friendly Ins. Co.

FATHER
12. Name: John Tregor
13. Birthplace: Md.

MOTHER
14. Maiden Name: Wilhemina Wilson
15. Birthplace: Md.

16 (a) Informant: Mr. Paul T. Tregoe
(b) Address: 3106 Baker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/19/47 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) MAR 17 1947 (Date rec'd by registrar) (b) Huntington Miller Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1947 at 1:30 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Occlusion

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Hayden M.D. Medical Examiner.
Date signed March 16, 1947

X

G49696

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

G49696 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Corner of Redwood & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 47d 2.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 320 Martingale Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Laurence E. Geddes

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Gladys T. Geddes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 18, 1889

8. AGE: Years	Months	Days	If less than one day
57	10	27	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Bosch Bros.

FATHER
12. Name Robert E. Geddes
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Lizzie Seeley
15. Birthplace Phila., Pa.

16 (a) Informant Mrs. Gladys T. Geddes
(b) Address 320 Martingale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/18/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15, 1947, at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 29, 1947 to March 15 1947 and that I last saw him alive on March 15 1947.

Immediate cause of death	Duration
Anoxia	
Due to Pulmonary Edema	
Due to Bronchiogenic Carcinoma	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Bragg M. D.
Address University Hospital Date signed 3-15-47

J. Bragg

G49697

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G49697
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 627 S. Grundy St.
(c) Hospital or institution: n/h
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 627 S. Grundy St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary L. Boog.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Thomas J Boog

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6-1867

8. AGE: Years 80 | Months - | Days 8 | If less than one day hr. min.

9. Birthplace Balto. md.
(Town, county, and state)

10. Usual Occupation at Home.

11. Industry or business ?

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16. (a) Informant Clarence C Boog (Son)
(b) Address 627 S. Grundy St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/18/47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave Rd.

18 (a) Funeral director John B Connelly
(b) Address 418 Eastern Ave. Essex 21.

19 (a) MAR 17 1947 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1947, at 5:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1947 to March 14 1947 and that I last saw her alive on March 14 1947.

Immediate cause of death	Duration
a Leucocytic Mye Uremia	?
Chronic Myocarditis	
Due to	
Due to	
Other Conditions Bronchopneumonia	1 mo

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jason Hyg Gaskel M. D.

Address 637 S. Caulking St. Date signed 3/15/47

X

G49698

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G49698

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St. City
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3508 W. Franklin St. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Elizabeth A. Higgins

3 (b) If veteran, name war —
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widowed

6 (b) Name of husband ~~or wife~~ James A. Higgins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1876

8. AGE: Years	Months	Days	If less than one day
70	3	14	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Pianist
11. Industry or business

FATHER
12. Name John W. Guest.
13. Birthplace England

MOTHER
14. Maiden Name Meriah Kirby
15. Birthplace Scotland

16 (a) Informant Little Sister of the Poor
(b) Address 1200 Valley Street City.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-18-47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director G. Howard Strong
(b) Address 3-06 W. North Ave

19 (a) MAR 17 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1947, at 8.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1947, to March 14 1947, and that I last saw her alive on March 14 1947.

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Cerebral Hemorrhage	5 days
Due to	
Other Conditions Arterio-Sclerosis	10 Yrs

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1631 E North Ave Date signed 3/15/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49699

KUHRMANN

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 471

Registered No. G49699

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway + Fairmont
(c) Hospital or institution:
Church Home + Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Dundalk 22
(If outside city or town limits, write RURAL and give town)
(d) Street No. 115 Williams Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles E Kuhrmann

3 (b) If veteran, name war

3 (c) Social Security Account No. 172-354

4. Sex M | Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of ~~husband or~~ wife Frieda Kuhrmann

6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) 14 Mar. 1890

8. AGE: Years 57 | Months – | Days 1 | If less than one day ____ hr. ____ min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Bethlehem Steel Co

FATHER 12. Name Wm Kuhrmann

FATHER 13. Birthplace Germany

MOTHER 14. Maiden Name Johanna Rheigel

MOTHER 15. Birthplace Germany

16 (a) Informant Mrs. Frieda Kuhrmann

(b) Address 115 Williams Ave., Dundalk 22

17 (a) Burial (b) Date thereof 3/19/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Eastern Ave.

18 (a) Funeral director Geo. H. Leimbach

(b) Address 1345 N. Lynch[illegible] St

19 (a) MAR 17 1947 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 Mar. 1947, at 8:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 23 Feb. 1947, to 15 Mar. 1947, and that I last saw him alive on 15 Mar. 1947.

Immediate cause of death	Duration
Carcinoma of lung	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 10 Mar. 1947

Major findings of operation: Carcinoma of left lung (inoperable)

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature O. J. Bennett

Address Church Home + Hosp. Date signed M. 3/15/47 D.

X

G49700

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G49700 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A.
(b) Street address 225 S. Ann St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 225 S. Ann St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Jeurss (Juetss)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/26/73

8. AGE: Years 3 74 | Months 3 | Days 20 | If less than one day hr. min.

9. Birthplace Balto-
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business at Home

FATHER
12. Name Unknown
13. Birthplace n

MOTHER
14. Maiden Name unknown
15. Birthplace n

16 (a) Informant Mr. Davis
(b) Address 2601 Maisel St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/18/37 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd

18 (a) Funeral director Seelz & Zeltz
(b) Address 463 E. Lexington St

19 (a) MAR 17 1941 (b) Registrar Huntington Williams

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/16 1937 at 8:40 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic CV disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. P. Schneider M.D.
Medical Examiner.
Date signed 3/16/37

X

G49701

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G49701 Registered No. 3198

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 W. Lexington St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) none
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1213 W Lexington St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Dowdy

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	colored	divorced

6 (b) Name of husband or wife Harry Dowdy
6 (c) If alive, give age , years

7. Birth date of deceased (mo., day, yr.) Oct ?, 1899

8. AGE: Years	Months	Days	If less than one day
47	5		hr. min.

9. Birthplace Greenville S. C. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business House work

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Caroline Young
15. Birthplace S. C.

16 (a) Informant Mrs Annie Dendy
(b) Address 1608 W. Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 17 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs K. R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (b) Lexington Williams, Registrar
Date rec'd by registrar MAR 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-17 1947, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-4 1947 to 3-17 1947 and that I last saw her alive on 3-17 1947.

Immediate cause of death	Duration
Congestive heart failure	Unknown
Due to Arteria Sclerosis	4
Due to Hypertension	11
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank A Saunders M. D.
Address 1029 N. Stricker St Date signed 3-18-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49702

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH (937)

G49702
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1811 Etting Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Slaughter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife Walter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 25, 1864

8. AGE: Years	Months	Days	If less than one day
83 82	-	16	hr. min.

9. Birthplace Anderson, S.C.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Gadie O'Bannon.
(b) Address 1811 Etting St.

17 (a) Burial (b) Date thereof Mar. 17, 1943
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Pt. Lookout National
Location Pt. Lookout, Md.

18 (a) Funeral director Mrs. K. R. Williams
(b) Address 322 N. Schroeder St.

19 (a) MAR 1943 (b) Frontis Fox Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1943 at 10 20 A M

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Moreschi, M.D.
Medical Examiner.
Date signed 3-13-43

G49703

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. G49703

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1533 N. Eden Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and name town)
(d) Street No. 1533 N. Eden Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Elizabeth Simuel Burden (Burton)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Tennessee Burden

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1907

8. AGE: Years 40 | Months | Days | If less than one day hr. min.

9. Birthplace Union, S.C.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Moses Simuel.
13. Birthplace Union, S.C.

MOTHER
14. Maiden Name Amanda Setter
15. Birthplace Union, S.C.

16 (a) Informant Henry Simuel
(b) Address 1618 Edmondson Ave

17 (a) Burial (b) Date thereof Mar. 17, 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N. Schroeder St.

19 (a) (b) Registrar
(Date rec'd by registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1947, at 10 30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, Spontaneous

Due to Hypertension & Senility

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Harold L. Kruger M.D.
Medical Examiner.
Date signed 3-14-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49704

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

G49704
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street
(c) Hospital or institution: City Morgue
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3048 Boston Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE J. ADELMANN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 5, 1883

8. AGE: Years	Months	Days	If less than one day
63	4	9 10	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business Atlantic Trans. Co.

FATHER
12. Name John Adelmann
13. Birthplace Carroll Co., Md.

MOTHER
14. Maiden Name Anna B. Weick
15. Birthplace Maryland

16 (a) Informant Chriscentia Wanger (sister)
(b) Address 3231 Fait Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 17, 1947 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem.
Location Herman Hill Rd.

18 (a) Funeral director Charles S. Seiler
(b) Address 3605 Fait Ave.

19 (a) (Date rec'd by registrar) MAR 17 1947 (b) Waterston Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1947, at 1 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☒ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: Found 1-1
(a) Date of injury 3-15-47 at M.
(b) Where did injury occur? Found: Foot of Potomac St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Found floating in harbor

23. Signature Earl L. Royer M.D.
Medical Examiner.
Date signed 3-17-47

G49705

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124 B

G49705
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correctly written. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 2918 Elliott Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME STEVE KOTT

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-10-2065

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Copper Work
11. Industry or business

FATHER
12. Name ? Kott
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Holy Trinity Russian Church
(b) Address 1723 E. Fairmount Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-18-47 (month) (day) (year)
(c) Cemetery or crematory Holy Trinity Russian
Location Stoney Run, Maryland

18 (a) Funeral director John A. Grebliauckas, Jr.
(b) Address 423 S. Paca Street

19 (a) 3-17-47 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14, 1947, at 6:45 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subarachnoid hemorrhare, spontaneous due to hypertensive cardio-vascular disease, Fractured skull (incident to subarachnoid hemorrhage)

Due to

Other Conditions Cirrhosis of liver

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Ryan M.D. Medical Examiner.
Date signed 3/31/47

VS 181

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Don
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give
(d) Street No. 2918 Elliott Street (If rural give location)
(e) Citizen of foreign country? (Yes
If yes, name country

3 (a) FULL NAME Steve Kott

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-10-2065

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not know

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace Russian (Town, county, and state)

10. Usual Occupation Copper work

11. Industry or business

FATHER
12. Name ? Kott
13. Birthplace Russian

MOTHER
14. Maiden Name Not know
15. Birthplace Russian

16 (a) Informant Holy Trinity Russian Church
(b) Address 1423 E. Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-18-47 (month) (day) (year)
(c) Cemetery or crematory Holy Trinity Russian
Location Stony Run Md

18 (a) Funeral director John A. Grebiankoff Jr.
(b) Address 423 S. Paca St.

19 (a) MAR 17 1941 (Date rec'd by registrar) (b) Huntington Mills

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14, 1947 at 6

21. I certify that I took charge of the remains described above, he
Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obta
by said Autopsy, Inspection or Inquiry, find that said deceased
to his death on the day stated above, and death in
opinion resulted from: natural causes ☑, accident ☐, suicide
homicide ☐, undetermined ☐ and that the causes of death w

IMMEDIATE CAUSE OF DEATH Fractured skull, subarachnoid hemorrhage

Due to

Other Conditions Cirrhosis of liver

(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause
death, fill in the following:
(a) Date of injury at
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in pub
place? While at work?
Means of injury

23. Signature Earl L Royer M.D.
Medical Examiner.
Date signed 3-15-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G49706 (Registered No.) G49706

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 935 S. Charles St.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 935 S. Charles St.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Wachsmuth,

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Charles Wachsmuth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21, 1861

8. AGE: Years 85 | Months 10 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore City
(Town, county, and state)

10. Usual Occupation Housewife,

11. Industry or business at home

FATHER
12. Name George Pfeil,
13. Birthplace Germany,

MOTHER
14. Maiden Name Unknown,
15. Birthplace Md.

16 (a) Informant Mr. August Wachsmuth,
(b) Address 1413 Light St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/17/47 (month) (day) (year)
(c) Cemetery or crematory Western,
Location Baltimore City,

18 (a) Funeral director C. Vernon Lemmon.
(b) Address 4611 Park Heights Ave.

19 (a) (Date rec'd by local registrar) (b) Registrar

MAR 17 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13, 1947, at 7.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/3/47 19__ to 3/13 1947, and that I last saw her alive on 3/ 19 47.

Immediate cause of death: Coronary Thrombosis — Duration: 10 days
Due to disease
Due to Arteriosclerosis
Other Conditions Senility
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1228 S. Charles St. Date signed

x 3 3/14/47

G49707

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G49707.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2108 Orleans St
(c) Hospital or institution:
b'

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2108 Orleans St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henrietta Jonas

(HENRIETTA JONAS)

MEDICAL CERTIFICATION

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Samuel Jonas

6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) Aug 31 186

8. AGE: Years 77 | Months 6 | Days 16 | If less than one day: hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wolf Gordon
13. Birthplace Germany

MOTHER
14. Maiden Name Ernestine Myer
15. Birthplace Germany

16 (a) Informant Samuel Jonas
(b) Address 2108 Orleans St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 17 1947
(month) (day) (year)

(c) Cemetery or crematory Hebrew Friendship
Location Balto County

18 (a) Funeral director Amos Lee
(b) Address 2632 Gardenville

19 (a) 1947 (Date rec'd by registrar) (b) Registrar

20. DATE OF DEATH March 16 1947, at 3 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1942 to Mar 16 1947 and that I last saw h[illegible] alive on Mar 15 1947.

Immediate cause of death	Duration
9 Cerebral Hemorrhage	2 days
Hemiplegia L.	
Due to Chronic Arteriosclerosis.	5 yrs
Due to Hayward. Insufficiency Pulmonary Edema	
Other Conditions Acute Cystitis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. G. Leopold M.D.
Address 156 N. Milton Ave Date signed 3/16/47

VS 150

HEBREW FRIENDSHIP CEMETERY.

X

NOTICE—Every item of information should be carefully supplied. The PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Funeral Directors

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49708

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G49708 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 506 East 23rd Street
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 506 East 23rd Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: MARY J. LAWLOR

3 (b) If veteran, name war: —

3 (c) Social Security Account No.:

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1888

8. AGE: Years: 59 | Months: | Days: | If less than one day: hr. min.

9. Birthplace: Ireland
(Town, county, and state)

10. Usual Occupation: At Home

11. Industry or business:

FATHER
12. Name: J. Maher
13. Birthplace: Ireland

MOTHER
14. Maiden Name: (?)
15. Birthplace: Ireland

16 (a) Informant: Mr. Michael Lawlor
(b) Address: 506 East 23rd Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/18/47 (month) (day) (year)
(c) Cemetery or crematory: Cathedral
Location: City

18 (a) Funeral director: WIEDEFELD AND SON
(b) Address: GREENMOUNT AVE & 22ND

19 (a) 3-17 1947 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/15/47 19 ; at M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-12 1946 to 3-15 1947 and that I last saw h alive on 3-15 1947.

Immediate cause of death: Generalized Carcinoma-
Tonsil — Duration: 1 yr.

Due to:

Due to: (c) (d) — over

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: O. D. Flynn, M.D.
M. D.
Address 11 E. Chase St Date signed 3-17-47

VS 150

X

G49709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G49709

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3302 Keswick Road.
(c) Hospital or institution:

13-5

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3302 Keswick Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alva S.Erb.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widowed.

6 (b) Name of husband or wife Elias Erb.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 24,1867

8. AGE: Years 80 | Months - | Days 19 | If less than one day hr. min.

9. Birthplace Maryland.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Cook.
13. Birthplace Md.

MOTHER
14. Maiden Name Mary S.Shipley.
15. Birthplace Md.

16 (a) Informant Charles R.Erb.
(b) Address North Point & Wire Mill Rd.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof March 18/47 (month) (day) (year)
(c) Cemetery or crematory Pipe Creek .
Location New Windsor, Carroll Co.

18 (a) Funeral director Chenoweth & Donovan.
(b) Address 3615-17 Chestnut Ave.

19 (a) MAR 17 1947 (Date received by Registrar) (b) Huntington for Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 14 1947 to March 15 1947. and that I last saw him alive on March 15 19 47.

Immediate cause of death 12-30 A M

Duration

Myocarditis
Arteriosclerosis
Coronal Insufficiency

Due to Cerebral hemorrhage
(Rt. Hemiplegia)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M.D.

Address 342 S Chester Date signed March 15-47

X

Dr Anderson
3001 Shannondale

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G49710
Registered No. 131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3405 Elmley Avenue
(c) Hospital or institution: 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3405 Elmley Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Catherine Sekene

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Henry J. Sekene
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6 - 1866

8. AGE: Years	Months	Days	If less than one day
80	5	9	hr. min.

9. Birthplace Balto - Md. (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name ✓
13. Birthplace ✓

MOTHER
14. Maiden Name ✓
15. Birthplace ✓

16 (a) Informant Mr. Herman J. Sekene
(b) Address 3405 Elmley Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/19/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd

19 (a) (b) Huntington Williams, M.D. Registrar
(Date filed by registrar)
MAR 17 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/15/1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/12/47 1947, to 3/15/ 1947, and that I last saw h[illegible] alive on 3/15/ 1947.

Immediate cause of death Bronchopneumonia — Duration
Due to Chronic nephritis
Due to Arteriosclerosis
Other Conditions Senility
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles A. Anderson M. D.
Address 3001 Shannondale Date signed 3/17/47

x

G49711

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. G49711

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [redacted]
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 30 years.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2909 Ailsa Ave.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Betty Coy.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife William Coy.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-22-1893

8. AGE: Years	Months	Days	If less than one day
54	11	21	hr. min.

9. Birthplace Amsterdam, Holland
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Secke Koldyk
13. Birthplace Holland

MOTHER
14. Maiden Name Antje
15. Birthplace Holland

16 (a) Informant Mrs. Anna F. Walter
(b) Address 2909 Ailsa Avenue

17 (a) Burial (b) Date thereof 3/18/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 (a) MAR 17 1947 Edward Williams, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 15 1947, at 9:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h.. alive on MARCH 15 1947

Duration

Immediate cause of death CARDIO RESPIRATORY FAILURE
Due to Generalized Toxemia.
Due to Intestinal Obstruction
Other Conditions Adhesions - Carcinoma Cervix Uterus.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Carcinoma of Sigmoid. Intestinal Adhesions.
of autopsy: not done.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John B Wells M.D.
Address St Jo Hop Date signed 3-18-47 M. D.

VS 150

G49712

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G19712 Registered No. 1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Caralsine St
(c) Hospital or institution:
St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3432 Elmora ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs. Hannah L Fischer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W | 6 (a) Single, married, ~~widowed~~ or divorced. W

6 (b) Name of husband or wife Charles E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 29-1883

8. AGE: Years 63 | Months 4 | Days 15 | If less than one day 7 hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER 12. Name Solomon Uhfelder

13. Birthplace Md.

MOTHER 14. Maiden Name Harriett Feg

15. Birthplace Md.

16 (a) Informant Mrs. John Lenhoff

(b) Address 3726 Echodale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/19/47 (month) (day) (year)

(c) Cemetery or crematory Loudon Pk.

Location Balto

18 (a) Funeral director Leopold J Ruck

(b) Address 5305 Harford Road

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/15/47 19 , at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/5/47 19 to 3/15/47 19 , and that I last saw her alive on 3/15/47 19

Immediate cause of death Cardiac Failure — Duration

Due to Myocardial Damage

Due to Pneumonia

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John B. Wells M.D.

Address St Josephs Hosp Date signed 3-19-47

Huntington Williams, M.D.

G49713 LESSNER

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

G49713 Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1403 N Caroline St
(c) Hospital or institution: St Josephs Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1610 N Bryan Park St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Elizabeth M Krouse.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married.

6 (b) Name of husband or wife William.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/27/90

8. AGE: Years	Months	Days	If less than one day
56	11	17	hr. min.

9. Birthplace Baltimore.
(Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name August Westerhoff
13. Birthplace Germany

MOTHER
14. Maiden Name Not Known
15. Birthplace Germany

16 (a) Informant Husband
(b) Address 1610 N Bryan St

17 (a) Burial (b) Date thereof 3/18/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director Laurence F Hoffmann
(b) Address 1639 Broadway

19 (a) MAR 17 1947 Filed by Wellington Williams, M.D.
(Date Rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/14/47 19 at 4:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/12 1947 to 3/14 1947, and that I last saw h 2d alive on 3/14 1947.

Immediate cause of death Cardiac Syncope
Fainting.
Duration

Due to Diabetes Mellitus.

Due to Diabetic gangrene - both lower extremities.

Other Conditions Contracture

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard F Young M.D.
Address 1 N Broadway. Date signed 3/17/47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V126

G49714

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hosp. 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 505 N. Mount St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME MAMIE KEATING

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: B | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Maurice Keating
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1901

8. AGE: Years: 45 | Months: 3 | Days: 16 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Walter Hill
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Ellen Collins
15. Birthplace: Essex, Va.

16 (a) Informant: Ellen Hill
(b) Address: 505 N. Mount St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Mar. 18, 1947 (month) (day) (year)

(c) Cemetery or crematory: Arbutus Memorial
Location

18 (a) Funeral director: Mrs. Kate B. Williams
(b) Address: 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) (b) Registrar: Washington Williams, M.D.

MAR 17 1947

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/14/1947, at 4:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/5/1947, to 3/14/1947, and that I last saw her alive on 3/14/1947.

	Duration
Immediate cause of death: Cardio. resp. failure	
Due to: Cerebral anoxia	
Due to: Pulmonary congestion and edema	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation: 3/11/47

Major findings of operation: Glioblastoma

of autopsy: Pulmonary congestion

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: R. Koerber, M. D.

Address: Univ. Hosp. Date signed: 3/14/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

EG 19715

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 130

Registered No. G49715

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton and Wilkins Avenues
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 wks 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1213 N. Bradford St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Willingham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 24 1935

8. AGE: Years	Months	Days	If less than one day
11	6	20	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Boyd Willingham
13. Birthplace West Va.

MOTHER
14. Maiden Name Lena Bruno
15. Birthplace Md.

16 (a) Informant Francis Willingham (Father)
(b) Address 1213 N. Bradford St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 20/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (a) MAR 17 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/16/47 1947 at 2:10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/28 1946 to 3/16 1947 and that I last saw him alive on 3/16 1947

Immediate cause of death Cardiac failure
Interstitial Glomerular nephritis - uremia

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Interstitial Glomerular nephritis

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D W Murtagh M D

Address Glyndon Date signed 3/16/47

X

G49716

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

G49716 Registered No.

1. PLACE OF DEATH: Eutaw Pl. & Brooks Lane.
(a) Baltimore City, Maryland
(b) Street address Cylburn Court Apts.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Cylburn Court Apts.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME LAURA SELDNER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Lippman Seldner.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 13, 1859.

8. AGE: Years	Months	Days	If less than one day
87	7	3	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Lewis Hecht,
13. Birthplace Germany.

MOTHER
14. Maiden Name Carrie Himmelrich,
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Eli Hecht,
(b) Address Cylburn Court Apts.

17 (a) Burial (b) Date thereof 3/18/47.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Balto. Md.

18 (a) Funeral director Harris Sonneborn
(b) Address 1902 Eutaw Place.

19 (a) MAR 17 1947 (Date rec'd by Registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16th. 1947, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to March 16 1947, and that I last saw h[illegible] alive on March 15 1947

Immediate cause of death	Duration
Senility	
Due to General debility	1 year
Due to Cerebro Sclerosis	5 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eli B. Hecht M. D.
Address Esplanade Apts. Date signed 3/17/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G49717

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93

Registered No. G49717

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 349- S. Bentalou Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ralph Patrick McMULLEN

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-14-1304

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Kate Hattie E (Cassell)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 25, 1888

8. AGE: Years 59 SMT 64 of 58 | Months 8 | Days 20 | If less than one day hr. min.

9. Birthplace Penna
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John M H McMullen
13. Birthplace Penna

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Lena Mae Westcott
(b) Address 349 S. Bentalou ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 18, 1947 (month) (day) (year)

(c) Cemetery or crematory ST Augustines
Location Elkridge Md.

18 (a) Funeral director Harry H Witzke
(b) Address 4101 Edmondson Ave

19 (a) MAR 17 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15, 1947, at 3.40 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic myocardial degeneration
Generalized arteriosclerosis
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 3-17-47

G49718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G49718 Registered No. 1248

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 410 Font Hill Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 410 Font Hill Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian M. Hale - Lillian Margaret Hale

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Russell S. Hale

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 11. 1907

8. AGE: Years 39 | Months 5 | Days 4 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation H. W.

11. Industry or business

FATHER
12. Name John G. Paul
13. Birthplace Md

MOTHER
14. Maiden Name Agnes Long
15. Birthplace Md

16 (a) Informant Russell S. Hale
(b) Address 410 S. Fonthill ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/18/47. (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location 2930 Frederick Rd.

18 (a) Funeral director Henry H. Keitzke
(b) Address 4 Edmondson ave

19 (a) MAR 17 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1947, at 8:45 M

21. I certify that death occurred on the date above stated that I attended deceased from 7/12 1946 to 3/15 1947
and that I last saw h[illegible] alive on 3/15 1947

Immediate cause of death: Cerebral hemorrhage
Due to: Cerebral Arteriosclerosis

Duration: 8 Months

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elliott W. Johnson M. D.
Address 3432 Frederick Ave Date signed

V S 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G49719 BALTIMORE CITY HEALTH DEPARTMENT G49719

CERTIFICATE OF DEATH 46B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1135 N. Fulton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1135 N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John M. Wallace

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Married

6 (b) Name of husband or wife Della E. Wallace
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
71			hr. min.

9. Birthplace Deals Island, Md.
(Town, county, and state)
10. Usual Occupation Oyster Man
11. Industry or business

FATHER
12. Name Nathaniel Wallace
13. Birthplace Md.

MOTHER
14. Maiden Name Mary E. Wallace
15. Birthplace Md.

16 (a) Informant William S. Wallace
(b) Address 1135 N. Fulton Ave.

17 (a) Burial (b) Date thereof 3/19/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Deals Island, Md.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantly Ave.

19 (a) (b)
(Date rec'd by registrar) Registrar

MAR 17 1947

MAR 17 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14 1947, at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1947 to March 14 1947 and that I last saw him alive on 3/13/47 19

Immediate cause of death	Duration
Carcinoma of Stomach	6 Mos.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jos. S. Julian Jr. M.D.
Address 1111 N. Calvert St. Date signed 3/19/47

X

G49720
509465

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

107

G49720
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Frederick
(c) City or town Thurmont.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Janet Louise Price

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-6-46

8. AGE: Years	Months	Days	If less than one day
	8	11	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Harry Price
13. Birthplace Md

MOTHER
14. Maiden Name Thelma Miller
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/17/47 (month) (day) (year)
(c) Cemetery or crematory United Brethren
Location Thurmont Maryland

18 (a) Funeral director William Cook Inc
(b) Address 2117 S Paul St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1947 at 6:13 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 6 1947 to March 17 1947, and that I last saw h.er alive on March 17 1947.

Immediate cause of death	Duration
Bronchopneumonia, chronic	
Post Tracheotomy	
Due to Capillary Bronchitis, acute	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Norbert Reynard M. D.
Address Johns Hopkins Hosp Date signed 3-17-47

MAR 17 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G19721

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G19721

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3502 Forest Park Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3502 Forest Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAX B. SEGALL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Jennie M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16/1869

8. AGE: Years	Months	Days	If less than one day
77	11	1	hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Merchant

11. Industry or business

FATHER
12. Name Solomon Zelig Segall
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah H.
15. Birthplace Russia

16 (a) Informant Mr. Philip Segall
(b) Address 3502 Forest Park Ave.

17 (a) Burial (b) Date thereof Mar 18/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Wash. Rd.
Location Washington Blvd.

18 (a) Funeral director SOL LEVINSON & BROS
(b) Address 1124-26 W. North Ave.

MAR 18 1947 Huntington Williams Mgr.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1947, at 8.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 1945 to March 17 1947, and that I last saw h alive on March 17, 1947.

Immediate cause of death	Duration
Myocardial Insufficiency	2 mos
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at AM
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sidney D. Levy, M.D.

Address 232 E. Eutaw Place Date signed 3/19/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49722

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √131a

G49722

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 32

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 530 Wilson (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Wiliams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	IV	wid.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/9/1898

8. AGE: Years	Months	Days	If less than one day
49	-	6	hr. min.

9. Birthplace Carolina Co., Virginia (Town, county, and state)

10. Usual Occupation LABORER

11. Industry or business

FATHER 12. Name UNKNOWN

13. Birthplace

MOTHER 14. Maiden Name UNKNOWN

15. Birthplace

16 (a) Informant CHARLEY JACKSON.

(b) Address 2219 DRUIDHILL AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-18-47 (month) (day) (year)

(c) Cemetery or crematory MT. AUBURN CEM.

Location BALTIMORE Md.

18 (a) Funeral director WILLIAM A JACKSON

(b) Address 916 PENNA. AVE.

19 (a) (Date rec'd by registrar) (b) (Registrar)

MAR 18 1947

Huntington Will

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/15 1947, at 4:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/6 1947 to 3/15 1947, and that I last saw h[illegible] alive on 3/15 1947.

Immediate cause of death	Duration
Uremia	
Due to Hypertensive Cardio-Vascular Renal Disease	3 days.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. J. Mansfield M. D.

Address Monday Hospital Date signed 3/20/47

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G49723 / 937

Registered No. G49723

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2111 E. North Ave
(c) Hospital or institution: St P
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2111 E. North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clarence H. Kroh

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Laura J. Wheeler
6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) Jan. 9, 1871

8. AGE: Years	Months	Days	If less than one day
76	2	6	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs Laura J. Kroh
(b) Address 2111 E. North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/18/47 (month) (day) (year)
(c) Cemetery or crematory Evergreen Baptist Church
Location Freeland, Md.

18 (a) Funeral director John F Henry Inc
(b) Address 645 Light St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15th 1947 at 5:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/15 1947 to 3/15 1947, and that I last saw h[illegible] alive on 19

Immediate cause of death BRONCHO PNEUMONIA — Duration

Due to ARTERIOSCLEROTIC - CARDIO VASCULAR DISEASE

Due to

Other Conditions DRY - GANGRENE - BOTH LOWER LEGS.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Christian F. Kroh M.D.
Address 1700 St. Paul St. Date signed 3/17/47

VS MAR 18 1947 Huntington Williams, M.D.

30 RIDGEWAY ST. 801 N. KENWOOD AVE.

G49724

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45F

Reg. No. G49724

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 112 N. Montford Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 112 N. Montford Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME FREDERICK A. ZICK

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 14, 1873

8. AGE: Years	Months	Days	If less than one day
74 71	2	1	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Packer
11. Industry or business Butler Bros.

FATHER
12. Name Frederick Zick
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Lighthower
15. Birthplace Germany

16 (a) Informant Mrs. Margaret Shaney
(b) Address 112 N. Montford Avenue

17 (a) Burial (b) Date thereof Mar. 19, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Trinity
Location Baltimore, Md.

18 (a) Funeral director William Cook, Inc.
(b) Address 1277 St. Paul Street

19 (a) MAR 18 1947 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1947, at 7:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1947 to March 15 1947 and that I last saw h[illegible] alive on March 15 1947.

Immediate cause of death Acute Cardiac Dilatation — Duration 3 Days

Due to Concussion of Brain — Duration 24 hrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William A. Cook
Address 801 N Kenwood Ave Date signed 3/16/47 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G49725
AB-108564

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46F

G49725
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26days
(e) Length of stay in Baltimore (yrs., mos., or days) 64yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 104 N. Wheeler Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Oscar Henning

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-03-8421

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 13- 1874

8. AGE: Years 72 | Months 3 | Days 2 | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Henning
13. Birthplace Germany

MOTHER
14. Maiden Name Charlotte
15. Birthplace Germany

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/18/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location

18 (a) Funeral director Chas P. Powell
(b) Address 2027 Edmondson Ave

19 (a) (b)

MAR 15 1947 Hunting for Williams Mill

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1947, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-19 47 to 3-15 19 47, and that I last saw h im alive on 3-15- 19 47.

Immediate cause of death: Carcinoma of common bile duct with metastases to liver. — Duration 8 mos.

Due to:

Due to:

Other Conditions: Bronchopneumonia. Acute atelectasis lung.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy 3/15/47 as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. H. Gibbs

Address Baltimore City Hosp. Date signed 3/16/47 M D

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

*G49726

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 E

G49726 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3231 Belmont ave.

(c) Hospital or institution: - 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) -

(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3231 Belmont ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dorothy Ann Lauterbach Stoner

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 216-05-8159

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Clarence H Stoner

6 (c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): Feb 6 1902

8. AGE: Years 45 | Months 1 | Days 11 | If less than one day: hr. min.

9. Birthplace: Haight Carroll Co Md (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business: -

FATHER: 12. Name: John F Lauterbach

13. Birthplace: Pleasant Hill Md

MOTHER: 14. Maiden Name: Annie W Lauterbach

15. Birthplace: Owings Mills Md

16 (a) Informant: Clarence H Stoner

(b) Address: 3231 Belmont Ave Balto Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 19 1947 (month) (day) (year)

(c) Cemetery or crematory: All Saints Cemetery

Location: Reisterstown Md

18 (a) Funeral director: Wm Berryman & Sons

(b) Address: Reisterstown Md

19 (a) (Date received by Registrar) MAR 19 1947 (b) Huntington Hollingsworth Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 17 1947, at 11:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1 1946, to Mar. 17 1947, and that I last saw her alive on Mar. 16 1947.

	Duration
Immediate cause of death: Pleural effusion.	2 weeks
Due to Generalized carcinomatosis	2 months
Due to Carcinoma transverse colon	5 mos.
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation: Oct. 1 1946

Major findings of operation: Perforated carcinoma, transverse colon

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide:

(b) Date of occurrence: at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury:

23. Signature: George H. Yeager.

Address: Medical Arts Bldg. Date signed: 3/17/47 (M. D.)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49727

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

G49727 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1214 Eutaw Place
(c) Hospital or institution: Balto Eye, Ear, Nose, & Throat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 610 W. 36 D St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** WILLIAM James STAFFORD

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/17/23

8. AGE: Years 24 | Months 2 | Days 0 | If less than one day hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name C. M. Stafford
13. Birthplace Balto., Md.

MOTHER 14. Maiden Name Estelle Mc Fadden
15. Birthplace Balto., Md.

16 (a) Informant Mr. Claude M. Stafford, father
(b) Address 610 W. 36th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 18 1947 (Date received by Registrar) (b) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/17 1947, at 6:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/14 1947, to 3/17 1947, and that I last saw h.IM. alive on 3/17 1947.

Immediate cause of death: Cardiac Failure — Duration:
Due to: Congenital Heart Disease
Due to:
Other Conditions: Nasal Bleeding
(Include pregnancy within 3 months of death)
Date of operation: NONE
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence 3/17/47 at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature P. N. Friedman M. D.
Address 1214 Eutaw Place Date signed 3/20/47

Huntington Williams, M.D.

G49728

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G49728

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2405 Elsinor Ave.
(c) Hospital or institution: 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2405 Elsinor Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NELLIE STEVENS RALEIGH

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Walter A. Raleigh
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Nov. 23, 1878
8. AGE: Years 68 | Months 3 | Days 23 | If less than one day hr. min.
9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Robert L. Stevens
13. Birthplace: Conn

MOTHER
14. Maiden Name: Agnes J. --?
15. Birthplace: 3120 St. Paul St.

16 (a) Informant: Mr. W. Allen Raleigh
(b) Address: 3120 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/18/47 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date rec'd by registrar) MAR 18 1947 (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 16, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 - 1947, to March 16 1947, and that I last saw h- alive on March 15 1947.

Immediate cause of death	Duration
Cerebral & pulmonary collapse.	1 month
Due to Lymphosarcoma of reticulum cell type	2 months
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 2-10-47
Major findings of operation: Lymphosarcoma glands
of autopsy: of neck.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Egbert H. Mortimer Jr M. D.
Address 2706 St Paul St Date signed 3/19/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C49729 107 Registered No. C49729

C49729

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd St. & Guilford Ave.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4301 Groveland Ave. (If rural give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry (Harry) D. Girdwood

3 (b) If veteran, name war: --

3 (c) Social Security Account No. 215-07-8864

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Mrs. Laura C. Girdwood
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Aug. 21, 1876

8. AGE: Years	Months	Days	If less than one day
71	6	25	hr. min.

9. Birthplace British West Indies (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business U.S.F.&G.

FATHER
12. Name James Girdwood
13. Birthplace Scotland

MOTHER
14. Maiden Name Margaret Cummins
15. Birthplace British West Indies

16 (a) Informant Hospital Records
(b) Address 33rd St. & Guilford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/19/47 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MAR 18 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16, 1947, at 8:49 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 15, 1947, to March 16, 1947, and that I last saw him alive on March 16, 1947.

Immediate cause of death	Duration
Bronchopneumonia	4 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. V. Lande, M.D.
Address Union Memorial Hospital Date signed 3-16-47 M. D.

G49730

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. G49730

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Monument & Rutland Avenue
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 6 wks
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 5003 Fait Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: MINNIE KANGAS

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec. 17, 1888

8. AGE: Years	Months	Days	If less than one day
58	2	28	hr. min.

9. Birthplace: Finland (Town, county, and state)
10. Usual Occupation: Housekeeper
11. Industry or business:

FATHER
12. Name: John Kangas
13. Birthplace: Finland

MOTHER
14. Maiden Name: Minnie ?
15. Birthplace: Finland

16 (a) Informant: Mr. Jannin Maki
(b) Address: 5003 Fait Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/19/47 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) (Date received by registrar) (b) Registrar

MAR 18 1947

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 15 1947, at 10:04 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 29 1947 to March 15 1947, and that I last saw h.er alive on March 15 1947.

Immediate cause of death: Pneumonitis — Duration:

Due to: Bronchogenic carcinoma
Extensive metastasis of mediastinum

Due to:

Other Conditions: Chronic Atelectasis
Chole Mania

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Heinz Beissinger M.D.
Address: Sinai Hospital Date signed 3/18/47

Hunter Lee Williams, M.D.

X

5:40 P.m
511 649731

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

168 R 649731

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1827 N. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDITH MAE DeBRY

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed or divorced: married

6 (b) Name of husband or wife: Joseph DeBry
6 (c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): March 30, 1897

8. AGE: Years: 52 | Months: 11 | Days: 16 | If less than one day: hr. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:

FATHER — 12. Name: Robert Holbrook
13. Birthplace: Maryland

MOTHER — 14. Maiden Name: Cinthie Allard
15. Birthplace: Maryland

16 (a) Informant: Records
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/47 (month) (day) (year)
(c) Cemetery or crematory: Parkwood Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 MAR 18 1947

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 16 1947, at 5:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 15 1947, to March 16 1947, and that I last saw her alive on March 16 1947.

Immediate cause of death	Duration
Lobar pneumonia due to Pneumococcus type 3	2 Days
Due to Rheumatic heart disease with mitral stenosis and	
Due to complete heart block	
Other Conditions	

(Include pregnancy within 8 months of death)

Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Robert C. Austen M.D.
Address: The Johns Hopkins Hosp. Date signed: 17 Mar 47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49732

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93c

Reg. No. G49732

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 925 N. Luzerne Ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James William Causey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Rose (nee Inglart)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23, 1905

8. AGE: Years	Months	Days	If less than one day
41	10	21	hr. min.

9. Birthplace Salisbury, Maryland (Town, county, and state)
10. Usual Occupation Industrial Laboratories
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Rose Causey - wife
(b) Address 925 N. Luzerne Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/18, 1947 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Rose St. & North Ave. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 18 1947 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 March 1947 at 6:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-10-1947 to 3-14-1947 and that I last saw h/ alive on 3-14-1947.

Immediate cause of death	Duration
Cardiac Failure	
Due to Coronary Thrombosis	
Due to Rheumatic CVD & Bundle Branch Block ??	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: No autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Causey M. D.
Address University Hosp Date signed 3-14-47

X

G49733

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G49733

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Wakeman's L
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLARENCE E KNIGHT
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of ~~husband or~~ wife Hilda Knight
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11th 1873

8. AGE: Years	Months	Days	If less than one day
73	9	6	hr. min.

9. Birthplace Harford Co. Md. (Town, county, and state)
10. Usual Occupation Clerical Work
11. Industry or business

FATHER
12. Name Joshua Knight
13. Birthplace Harford Co. Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16. (a) Informant Charles A. Knight
(b) Address 3600 Elkader Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/47 (month) (day) (year)
(c) Cemetery or crematory Abington
Location Harford Co. Md

18 (a) Funeral director McClean Cook Inc
(b) Address 1217 St. Paul St.

MAR 18 1947 (Date rec'd by registrar) (By) Huntington Williams M.D. Registrar

V S 150 Medical Examiners

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/17 1947, at 3 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/17 1947 to 3/17 1947 and that I last saw him alive on 3/17 1947

Immediate cause of death Coronary Occlusion — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stanley Myerberg M. D.
Address Sinai Hosp Date signed 3/17

Signature Enoch H. Rozen, M.D.

G49734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G49734

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 624 George St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 624 George Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert Milburn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Theresa Milburn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace St. Mary's County Md. (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Ellie Milburn
13. Birthplace St. Mary's County Md.

MOTHER
14. Maiden Name Eliza Groads
15. Birthplace St. Mary's County Md.

16 (a) Informant Theresa Milburn
(b) Address 564 Orchard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 (month) -47 (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave

19 (a) MAR 18 1947 (Date received by registrar) (b) Hunting for Millburn, Md. (Address)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13, 1947, at 8:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 2 19 47 to 3/12/47 19; and that I last saw h. alive on 3/14/47 19.

Immediate cause of death	Duration
Myocardite	uncertain
Due to Senility	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address 401 Edgewood Rd Date signed 3/17/47

G49735

JL - 7344?

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G49735 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-10-23
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 738 Meeche St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elijah J. Smith

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Nancy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 27 1875

8. AGE: Years	Months	Days	If less than one day
71	2	19	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name William Smith
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof Mar 20 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary-
Location Halstead
18 (a) Funeral director A. Daniel Hill
(b) Address 9 E. 8
19 (a) MAR 18 1947 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1947, at 1.15A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 22 1942 to Mar. 15 1947, and that I last saw h. in alive on March 15 1947.

Immediate cause of death Bronchopneumonia — Duration 1 mth
Due to
Due to
Other Conditions Hypertensive Heart Disease — 7
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Robinson Jr M. D.
Address Balt. City Hosp. Date signed 3/15/47

G49736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered G49736

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2401 Shirley Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie Mary Plotkin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Joseph Paul
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Isadore
13. Birthplace Russia

MOTHER
14. Maiden Name Perguee
15. Birthplace Russia

16 (a) Informant Joseph Plotkin
(b) Address 2401 Shirley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-18-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1409 E Baltimore St

19 (a) (Date rec'd by registrar) (b) Filed Huntington Willis Funeral Home

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/17/47 19 , at 2:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/11 1947 to 3/17 1947, and that I last saw her alive on 3/17 1947

Immediate cause of death	Duration
Intracerebral hemorrhage due to subarachnoid aneurysm	
Due to Hypertension & Arteriosclerosis	
Due to	
Other Conditions Hypertension & Arteriosclerotic heart disease	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Coroner

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address Sinai Hosp Date signed 3/17/47 M. D.

V S 150
MAR 18 1947

83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49737

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

98

Registered No. G49737

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 907 Linden Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 907 Linden Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louise N. Gray

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William Eugene Gray

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years 77 | Months | Days | If less than one day hr. min.

9. Birthplace Howard Co. Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace —

MOTHER 14. Maiden Name Unknown

15. Birthplace —

16 (a) Informant Estelle Bryce

(b) Address Simpsonville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 19, 1947 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director Mrs Kate R. Williams

(b) Address 322 N Schroeder St

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams, MD

MAR 18 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/17/47 1947 A.M. P.M. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/3/47 19 to 3/17/47 19, and that I last saw h alive on 3/9/47 19

Immediate cause of death Bronchial Thrombosis — Duration 2 Days

Due to Edema of Lungs

Due to Chronic Nephritis

Other Conditions Contributing to Death

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Lee Ellis M. D.

Address 924 N Eutaw Date signed 3/18/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49738

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G49738

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) H

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 120 Amity Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ESTELLE J. BOULDIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	colored	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 17, 1890

8. AGE: Years	Months	Days	If less than one day
56	2	~29	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name William Henry
13. Birthplace Cambridge, Md.

MOTHER
14. Maiden Name Sarah Bailey
15. Birthplace Baltimore Md.

16 (a) Informant Wally Bouldin
(b) Address 886 Pierce St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 20, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mr. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16, 1947, at 1.35 P M

21. I certify that I took charge of the remains described above, held an insp. & Inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D. Medical Examiner.
Date signed 3-17-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49739

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 927

Registered No. G49739

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1303 Myrtle Ave,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1303 Myrtle Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura E. Bradley Smith.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 29, 1917

8. AGE: Years 29 | Months 3 | Days 16 | If less than one day hr. min.

9. Birthplace Scotland Neck N. C.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Stewart Smith
13. Birthplace N. C.

MOTHER
14. Maiden Name Harriett Bradley
15. Birthplace Virginia

16 (a) Informant Mrs Adella Bradley
(b) Address 1303 Myrtle Ave,

17 (a) Burial (b) Date thereof Mar. 19, 1941
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie A. Williams
(b) Address 322 N. Schroeder St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1941, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 2 1941 to March 15 1941, and that I last saw h[illegible] alive on March 15 1941.

Immediate cause of death

Pulmonary Hemorrhage

Due to Phthisis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
Past Life

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place) CHARLES T. WOODLAND
(e) Means of injury

23. Signature [signature]
M. D.
Address 816 HARLEM AVE. Date signed March 16 1941

VS 150

Christiana Williams M.D.

9 45 P.M

5116 G49740

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 309

Registered No. G49740

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 3-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1619 E. Fairbard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Burrell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Susie Burrell

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) June 23, 1893

8. AGE: Years 53 | Months 8 | Days 23 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Robert Burrell
13. Birthplace Virginia

MOTHER 14. Maiden Name Sarah Pipes
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 19 47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem. Md.
Location A.A. County Md.

18 (a) Funeral director Mrs. Ethel A. Elliott Dept
(b) Address 1129 N. Caroline St.

19 (a) (Date rec'd by registrar) (b) Washington Wilmington

MAR 18 1947

VS 140

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1947, at 9 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 13 1947 to March 16 47 and that I last saw h[illegible] alive on March 16 47

Immediate cause of death: Meningitis — Duration: [illegible]

Due to: syphilis or tuberculosis — unknown

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E. Mason M. D.
Address Johns Hopkins Hosp. Date signed 17 Mar 47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49741

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G49741

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 432 N. Regester St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 432 N. Regester St (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ida Dennie Hammond

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William Hammond

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 9, 1879

8. AGE: Years 67 | Months 3 | Days 6 | If less than one day hr. min.

9. Birthplace Eastern Shore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Wellesley Riley
13. Birthplace Md

MOTHER
14. Maiden Name Victoria ?
15. Birthplace Md.

16 (a) Informant Ernest Dennis
(b) Address 432 N Regester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/18/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location A A County Md

18 (a) Funeral director Mrs. Pet. A. Elbert Dept
(b) Address 1109 N. Carrollton Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS 199 MAR 18 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-15 1947 at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1947 to March 1947, and that I last saw h.. alive on March 15 1947.

Immediate cause of death: Pneumonia, hypostatic / Respiratory Failure. — Duration: 1 day

Due to: Senility

Due to: Myocardial degeneration

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. E. Burwell M. D.
Address 141 Augusta Date signed 3-18-47

X

G49742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G49742

516

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Raymar ave
(c) Hospital or institution: West Balto. Gen'l
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 11 Paradise ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clarence R. Morrison

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Flora K. Bowles
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Oct 12, 1881

8. AGE: Years 65 | Months 5 | Days 3 | If less than one day: hr. min.

9. Birthplace Page Co. Va. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER — 12. Name Richard H. Morrison
13. Birthplace Va.

MOTHER — 14. Maiden Name Albertia Z. Woodward
15. Birthplace Va.

16 (a) Informant Mrs Flora K. Morrison
(b) Address 11 Paradise ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-19-47 (month) (day) (year)

(c) Cemetery or crematory London Park
Location Baltimore

18 (a) Funeral director Elliott J. White
(b) Address 2540 Gilsprings Lane

19 (a) MAR 18 1947 (Date rec'd by registrar) (b) Huntington, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1947, at 9:49 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1, 1947, to March 15 1947, and that I last saw h.i.m. alive on March 15 1947.

	Duration
Immediate cause of death: respiratory failure	
Due to: multiple carcinomatosis	
Due to: ca of prostate	
Other Conditions: —	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature: Louis Hanks Polus M.D.
Address: Woodbourne Hospital, Baltimore Date signed: 3/16/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B

Registered No. G49743

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2035 Eagle St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2035 Eagle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mattie S. Lutz

3 (b) If veteran, name war	3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Harrey E. Lutz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1891

8. AGE: Years	Months	Days	If less than one day
56	—	22	hr. min.

9. Birthplace North Carolina
(Town, county, and state)
10. Usual Occupation Mid Wife
11. Industry or business Self

FATHER
12. Name Rev. Henry C. Mason
13. Birthplace North Carolina

MOTHER
14. Maiden Name Mary S. Unknown
15. Birthplace Calvert County

16 (a) Informant Mr. Harry E. Lutz
(b) Address 2035 Eagle St.

17 (a) Burial (b) Date thereof 3/20/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore

18 (a) Funeral director Frederick A. Colt
(b) Address 1200 W Fayette St

19 (a) MAR 18 1947 Huntington Williams M.D.
(Date received by registrar)

MEDICAL CERTIFICATION 40

20. DATE OF DEATH March 16 1947, at 10:A M

21. I certify that death occurred on the date above stated, that I attended deceased from 1/24 1947 to 3/16 1947
and that I last saw h alive on 3/16 1947

Immediate cause of death

	Duration
Cardiac Decompensation	
Due to Mitral Stenosis	8
Due to Pulmonary Congestion & Fibulation	
Other Conditions	
Thrombus of Popliteal vein (Include pregnancy within 3 months of death)	1/24/47
Date of operation	
Major findings of operation	
of autopsy	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Chas J Rahn
Address 2145 W Balto St Date signed 3/17/47
M. D.

VS 150

G49747 BALTIMORE CITY HEALTH DEPARTMENT 181 G49747

CERTIFICATE OF DEATH

Registered No. Sorel City, Quebec, Canada.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: S.S. Mayflower
(a) State Canada (b) County Prov. Quebec
(c) City or town Sorel City
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Canada.

3 (a) FULL NAME ROBERT PELOQUIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1911

8. AGE: Years 36 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Sorel City, Quebec
(Town, county, and state)

10. Usual Occupation Seaman

11. Industry or business Mayflower Shipping Ltd.

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden Name Cordellia ?
15. Birthplace unknown

16 (a) Informant British Council
(b) Address Baltimore, Maryland

17 (a) removal (Burial, cremation, or removal) (b) Date thereof 3/18/47 (month) (day) (year)
(c) Cemetery or crematory Sorel
Location Sorel City, Quebec, Canada

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

MAR 18 1947 (Date rec'd by registrar) (b) Huntington Williamsport

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17, 1947 at 9.30 a M

21. I certify that I took charge of the remains described above, held an insp. & inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock

Due to 2nd & 3rd degree burns involving 95% body surface

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-14-47 at 6.15 p. M.
(b) Where did injury occur? Mayflower ship-Point Look out
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? Yes
(d) Means of injury Explosion followed by fire

23. Signature Howard J. Walden II M.D.
Medical Examiner.
Date signed 3-17-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49745

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G49745 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2109 E. Fairmount Avenue
(c) Hospital or institution:
6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(3) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2109 E. Fairmount Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Emerson Mugrage

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07-2388

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1895

8. AGE: Years	Months	Days	If less than one day
51	8	7	hr. min.

9. Birthplace Dexter City, Ohio (Town, county, and state)
10. Usual Occupation Operator - Press Machine
11. Industry or business Anchor Post & Fence Co.

FATHER
12. Name Reece Mugrage
13. Birthplace Dexter City, Ohio

MOTHER
14. Maiden Name Maude Hoffman
15. Birthplace Virginia

16 (a) Informant Chance Mugrage
(b) Address 2109 E. Fairmount Avenue

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 3/20/47 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) MAR 19 1947 (Date rec'd by Reg'r) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1947 at 3.30 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from March 1 1947 to March 16 1947, and that I last saw h[illegible] alive on March 16 1947.

Immediate cause of death	Duration
Cerebral apoplexy	acute
Due to Cerebral arteriosclerosis & Chronic Hypertension	1 Yr 9 Mo
Due to	
Other Conditions Paresis from Cerebral apoplexy (Include pregnancy within 3 months of death)	1 Yr 9 Mo.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 400 E. Fratt St. Date signed 3/17/47

VS 150

G49746

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G49746 Registered No. 1318

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1719 Braddish Avenue
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1719 Braddish Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Georgia Grewe

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Joseph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept. 4, 1862

8. AGE: Years 84 | Months 6 | Days 12 | If less than one day: hr. min.

9. Birthplace: Fork, Maryland
(Town, county, and state)

10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Edward Clayton
13. Birthplace: Fork

MOTHER
14. Maiden Name: Ellen France
15. Birthplace: Fork

16 (a) Informant: Mrs. Eva Kirkorian
(b) Address: 2319 W. North Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 19-47 (month) (day) (year)
(c) Cemetery or crematory: Fork, M.E. Cumetary
Location: Fork, Maryland

18 (a) Funeral director: Wm. Cook, Inc.
(b) Address: 1217 St. Paul Street

19 (a) [illegible] 19 1947 (b) Huntington Hobbs (Signature of registrar) Registrar, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16, 1947 at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 26th 1947 March 16 1947 and that I last saw her alive March 16, 1947.

Immediate cause of death: Chranic Nephritis — Duration: 2 Yrs
Due to: Coma — Duration: 1 Dy.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. K. Crellin M. D.
Address 2574 W. North Ave Date Mar 20 1947

VS 150

G49747 G49747

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

CWK-106446 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 4- 22-
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1731 W. Hollins Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertie May Brooks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 1-1911

8. AGE: Years 35 | Months 6 | Days 12 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Severn Collins (D)
13. Birthplace Maryland

MOTHER
14. Maiden Name Alice Hall (D)
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/47 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore Md

18 (a) Funeral director Wilson Godfrey Inc
(b) Address 214 E Lexington St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1947, at 9:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 21 1946, to March 13 1947, and that I last saw her alive on March 13 1947.

Immediate cause of death	Duration
Carcinoma of colon with metastases	
Due to	
Due to	
Other Conditions Uremia due to renal failure. (Include pregnancy within 3 months of death)	

Date of operation 3/6/47

Major findings of operation Exploratory laparotomy for intractable pain

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. B. Gibbs M. D.
Address Baltimore City Hospitals Date signed 3/14/47

Birth certificate G49738 G-79497

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G49738

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton and Wilkens Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3811 Pascal St. 26 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby - Bourne

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed, or divorced~~
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/15/47

8. AGE: Years	Months	Days	If less than one day
			11 hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Douglas Bourne
13. Birthplace Pa.

MOTHER
14. Maiden Name Virginia Rogers
15. Birthplace New Jersey

16 (a) Informant Douglas Bourne
(b) Address 3811 Pascal St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/18/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Cathedral

18 (a) Funeral director Martin Bailey & Sons
(b) Address 1827 W. North Ave.

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

VS 150 MAR 18 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/16 1947, at 5:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/15 1947 to 3/16 1947, and that I last saw him alive on 3/16 1947.

Immediate cause of death	Duration
Cardiac failure	
Premature infant	
Due to	6 Mo.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. Huntington Williams
Address 1 E. Eager Date signed 3/16/47 M. D.

X

G49749

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

G49749 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2534 W Baltimore St
(c) Hospital or institution:
?
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 24yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2534 W. Baltimore ST (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia Lee Wade

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband ~~or wife~~ Louis R. Wade Jr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23 1921

8. AGE: Years	Months	Days	If less than one day
25	8	23	hr. min.

9. Birthplace Mobile Alabama (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name George J. Christ
13. Birthplace Balto.

MOTHER 14. Maiden Name Margaret Erb
15. Birthplace Balto.

16 (a) Informant Louis R Wade Jr
(b) Address 2534 W. Baltimore ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 19 1947 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave & Longwood St

18 (a) Funeral director Harry H Wetzler
(b) Address 4101 Edmondson Ave

19 (a) MAR 18 (Date rec'd by Registrar) (b) Washington Village, M.K. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 11 1945 to Mch 16 1947, and that I last saw h[illegible] alive on Mch 13 1947.

Immediate cause of death	Duration
Melanotic sarcoma - scalp	3 yrs
Metastases - general	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Oct. 1945 & July '46
Major findings of operation: Removal of melanotic sarcoma, & glands.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Grant Hoard M. D.
Address Medical Arts Bldg Date signed 3/18/47

VS 150

X

G49750

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G49750

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 403 Rock Glen Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 403 Rock Glen Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mason L. Kirwan

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War 1	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Married

6 (b) Name of husband or wife Marie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 19, 1896

8. AGE: Years	Months	Days	If less than one day
50	3	27 28	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Plumber
11. Industry or business Own Business

FATHER
12. Name Wm T. Kirwan
13. Birthplace Md

MOTHER
14. Maiden Name Margaret Weyler
15. Birthplace Md

16 (a) Informant Mrs Marie Kirwan
(b) Address 403 Rock Glen Rd

17 (a) Burial (b) Date thereof 3/20/47.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location 5501 Frederick Road.

18 (a) Funeral director Harry H. Kittle
(b) Address 4101 Edmondson ave

19 (a) (Date rec'd by registrar) (b) Registrar

V S 150

MAR 18 1947

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/17/47. 19, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 16 1946, to March 17 1947, and that I last saw him alive on March 17 1947.

Immediate cause of death	Duration
Coronary occlusion	2 hours
Due to Coronary sclerosis	unknown
Due to	
Other Conditions Essential hypertension	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo J. Gover M. D.
Address 1 Wallow Hill ave Date signed 3/18/47

X

G49751

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G49751

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 224 N. Biddle St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 224 N. Biddle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Mary Ayers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Henry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4, 1904

8. AGE: Years 42 | Months 9 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Charles Ayers
13. Birthplace Balt. Md.

MOTHER
14. Maiden Name Elizabeth C. Ayers
15. Birthplace Maryland

16 (a) Informant Marguerite C. Ayers
(b) Address 224 N. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/19/1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director L. L. Preston Linberry
(b) Address 510 N. Fremont St.

19 (a) MAR 16 1947 (Date rec'd by registrar) (b) [illegible]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1947, at 3:40 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 10 1947, to March 15 1947, and that I last saw her alive on March 14 1947.

Immediate cause of death	Duration
Pulmonary Embolism	5 days
Due to Endocarditis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]

Address 1422 E. Chase St. Date signed 3/15/47

VS 150

G49752

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G49752

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 919 N. Gilmor St.
(c) Hospital or institution:
16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 919 N. Gilmor St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sally Holley Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex Female | 5 Color or race Colored | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Joshua M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22, 1893

8. AGE: Years 53 | Months 7 | Days 25 | If less than one day hr. min.

9. Birthplace Lunenburg Co. Va
(Town, county and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER
12. Name Thomas Jones
13. Birthplace Lunenburg Co. Va

MOTHER
14. Maiden Name Elizabeth Jones
15. Birthplace Lunenburg Co. Va

16 (a) Informant Mrs. Edna Holley
(b) Address 919 N. Gilmor St

17 (a) Burial (b) Date thereof 3/20/1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Wm. Chas. H. Holland
(b) Address 1631 Druid Hill Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 MAR 18 1947 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/16/1947, at 5:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/16/47, to 19..., and that I last saw h... alive on 19...

Immediate cause of death	Duration
Cerebral Hemorrhage	1 hr
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hazelcorn M. D.
Address 1131 Harlem Date signed 3/17/47

G49753

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 121

G49753

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division ST
(c) Hospital or institution: Provident Hosp 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 da
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1314 Mosher ST
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Robert Lewis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 24 1902

8. AGE: Years 44 | Months 6 7 | Days 8 13 | If less than one day hr. min.

9. Birthplace Lancaster Co
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Washington Carter

13. Birthplace Lancaster Co. Va

MOTHER 14. Maiden Name Harriett Patty

15. Birthplace Lancaster Co. Va

16 (a) Informant Mrs. Robert L. Lewis

(b) Address 1314 N. Mosher St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/1947 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore, Md.

18 (a) Funeral director Wm. Geo. H. Holland

(b) Address 1031 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Hitt Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR 16 1947, at 12:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from MAR 4 1947, to MAR 16 1947, and that I last saw her alive on MAR 16 1947.

Immediate cause of death: Pulmonary Embolism — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3/6/47

Major findings of operation: Fibromyoma Uteri, Chronic Appendix

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature B. Harris / T. White M.D.

Address Provident Hosp Date signed 3/16/47

G49754

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G49754

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1121 Shields Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rush Williams

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-15-1907

8. AGE: Years	Months	Days	If less than one day
39	11	28	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Orderly

11. Industry or business Provident Hosp.

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Oscar Williams (Friend)
(b) Address 1121 Shields Pl.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/18/47 (month) (day) (year)
(c) Cemetery or crematory Western Star
Location Catonsville, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N. Carrollton Ave

19 (a) MAR 19 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1947, at 6.30 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions Fracture left forearm

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-13-47 at 5:20 P M. 14 yr
(b) Where did injury occur? Provident Hosp.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial pl. While at work? yes
(d) Means of injury Fell from upper deck (2nd floor)

23. Signature Earl L. Royer M.D. Medical Examiner

Date signed 3-14-47

VS 181

FRONT: WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49755

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 108

Registered No. G49755

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 118 Hammerdackerl ct
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore ~~(yrs.,~~ mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 118 Hammerdackerl Ct (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Victoria Mackey

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace West Point Va (Town, county, and state)

10. Usual Occupation Dr

11. Industry or business

FATHER 12. Name John Ramsdale
13. Birthplace Va

MOTHER 14. Maiden Name Miller Page
15. Birthplace Va

16 (a) Informant Mary MacKey
(b) Address 118 Hammerdackerl ct

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/18/47 (month) (day) (year)
(c) Cemetery or crematory Richmond
Location Va

18 (a) Funeral director Jesse L Brown
(b) Address 108 [illegible]

19 3/18 1947 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150-

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/14/47, 19, at 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/11 19 47 to 3/14 19 47.
and that I last saw b alive on 19

Immediate cause of death Lobar Pneumonia — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John R Rhett M.D.
Address 2 [illegible] Date signed 3/18/47

3:16 AM

511783 G49756

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G49756

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 37
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 day
(e) Length of stay in Baltimore (yrs., mos., or days) 68 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and name of town)
(d) Street No. 1511 Aliceanna St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa Kaczorowski

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-10-0772

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed or divorced: Married

6 (b) Name of husband or wife: Michael Kaczorowski

6 (c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) 2-14-98 1869

8. AGE: Years 68 | Months 1 | Days 4 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name
13. Birthplace Poland

MOTHER
14. Maiden Name
15. Birthplace Poland

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 3-21-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St Stanislaus
Location Baltimore Md

18 (a) Funeral director George A Welsh

(b) Address 705-L Aisquith St

19 (a) (Date rec'd by registrar) (b) Registrar

VS MAR 18 1947

Huntington Williams, M.D.

MEDICAL CERTIFICATION 3:16 P.M.

20. DATE OF DEATH March 18 1947, at 2:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 16 1947, to March 18 1947 and that I last saw her alive March 17 1947.

Immediate cause of death: Hemorrhage from vessel of brain with hemiplegia right — Duration: 2 days

Due to: Hypertensive cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert C. Austrian M.D.

Address Johns Hopkins Hosp Date signed 18 Mar 47

G49757

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

G49757
Reference No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... The correct age is especially important. Physicians: please write the ... the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1710 Hollins St.
(c) Hospital or institution:
Home 19-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore - 23
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1710 Hollins St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Karol Charles Bodnar

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-07-6385

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband~~ or wife Anna
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Dec 20 - 1885

8. AGE: Years	Months	Days	If less than one day
61	2	27	...hr. ...min.

9. Birthplace Poland
(Town, county, and state)
10. Usual Occupation Briber maker
11. Industry or business B & O Railroad

FATHER
12. Name Karl Bodnar
13. Birthplace Poland

MOTHER
14. Maiden Name Theodora
15. Birthplace Poland

16 (a) Informant Mrs Anna Bodnar
(b) Address 1710 Hollins St

17 (a) Burial (b) Date thereof 3-19-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Michaels Greek
Location Balto. County

18 (a) Funeral director George A Huber
(b) Address 705 S. Ann St.

19 (a) ... (b) ...
(Date rec'd by registrar) Registrar

MAR 18 1947 Washington Ward

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1947 at 6 55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1 1947 to 3/16 1947, and that I last saw him alive on 3/16 1947.

Immediate cause of death	Duration
Carcinoma of oesophagus	6 mos.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Wilkes M. D.
Address 1036 Wilkens Date signed 3/17/47

as X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G49758 / 469 G49758

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md (b) County Pr. Geo's Co.
(c) City or town Greenbelt (If outside city or town limits, write RURAL and give town)
(d) Street No. 3a Crescent Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry Goldstein

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married

6 (b) Name of husband or wife Kate
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-25-00

8. AGE: Years	Months	Days	If less than one day
46	10	23	hr. min.

9. Birthplace Roumania (Town, county, and state)
10. Usual Occupation Gas Station Attendant
11. Industry or business

FATHER 12. Name Saul Goldstein
13. Birthplace Russia

MOTHER 14. Maiden Name Rebecca
15. Birthplace Austria

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof 3-19-47 (month) (day) (year)
(c) Cemetery or crematory Edgewood Road
Location Washington D C

18 (a) Funeral director Goldberg Funeral Home
(b) Address 4717-9th St. N.W. Wash.

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

VS 150

MAR 18 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1947, at 8:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 10 1947 to Mar. 18 1947 and that I last saw him alive on Mar. 18 1947.

Immediate cause of death	Duration
Carcinoma of pancreas	
Whipple operation	
Due to Diabetes Mellitus	
Due to Hepatitis	
Metastatic Carcinoma	
Other Conditions Anasarca	
jaundice	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature A. M. Knight M. D.
Address Date signed

X

G49759

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G49759 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5028 Edgar Terrace
(c) Hospital or institution:

27

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5028 Edgar Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry W?Harp Sr.

530 W.M

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Lillian B.Harp
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 9,1871

8. AGE: Years	Months	Days	If less than one day
75	7	12	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name William Harp
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Sarah Taylor
15. Birthplace Md.

16 (a) Informant Mrs. Elizabeth Steiner
(b) Address 5028 Edgar Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 20/47 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Orleans St.

19 (a) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS. 150 MAR 18 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17/47 19 , at 530 M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1 1944 to March 17 1947. and that I last saw him alive on March 17 1947

Immediate cause of death	Duration
Coronary Occlusion	3/15/47
Due to Arterio-Sclerotic Heart disease	1/1944
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Roemer M.D.
Address 801 N Kenwood Ave Date signed 3/17/47

X

11:10 P.M.

A 53649760

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

C49760

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State New York County
(c) City or town Schenectady (If outside city or town limits, write RURAL and give town)
(d) Street No. R.D. #5 Box 187 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mark Sutter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1946

8. AGE: Years 04 Months Days 25 If less than one day hr. min.

9. Birthplace State of New York (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Edsel Sutter
13. Birthplace Penna.

MOTHER
14. Maiden Name Ruth J. Simonson
15. Birthplace Penna.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-18-47 (month) (day) (year)

(c) Cemetery or crematory
Location Schenectady N.Y.

18 (a) Funeral director Frank D. Ellis Inc.
(b) Address 52 N. Market St

19 (a) (Date received by registrar) (b) Registrar

MAR 18 1947

VS-150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1947, at 11:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 14 1947 to March 17-47 and that I last saw h alive Mar. 17 1947

Immediate cause of death: Capillary Bronchitis — Duration

Due to: Congenital Heart disease - Cyanotic group

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert Simmons M. D.

Address Johns Hopkins Hosp. Date signed 3-18-47

X

AB-~~6[illegible]~~761

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G49761

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3mos- 5days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2731 Vermont Ave
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Winifred Mitchell or Katherine Winifred Gibson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 12- 1925

8. AGE: Years 21 | Months 3 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Anthony Mitchell
13. Birthplace Italy

MOTHER
14. Maiden Name Marie Harrison
15. Birthplace Baltimore, Maryland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof March 20-1947 (month) (day) (year)
(c) Cemetery or crematory Lehnpahp
Location Edmondson Ave

18 (a) Funeral director Randall Lloyd
(b) Address 3125 Highland Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 18 1947

vs

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15- 1947, at 6.30PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-10- 1946 to 3-15 1947 and that I last saw her alive on 3-15 1947

Immediate cause of death	Duration
Respiratory failure	
Due to Pulmonary tuberculosis 2 yrs	
Bilateral	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 3/16/47

X

G49762

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G49762 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1307 Roundhill Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) LIFETIME

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1307 Roundhill Rd.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Emma H. Berger

3 (b) If veteran, name war

3 (c) Social Security Account No. ——

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	WIDOWED

6 (b) Name of husband or wife GEORGE BERGER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 30, 1870

8. AGE: Years	Months	Days	If less than one day
76	8 9	17	hr. min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name HERMAN KLOPPEL
13. Birthplace GERMANY

MOTHER
14. Maiden Name EMMA WATTENSCHEIDT
15. Birthplace GERMANY

16 (a) Informant HERBERT K. BERGER
(b) Address 1307 ROUND HILL RD.

17 (a) BURIAL (b) Date thereof 3 20 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location BALTIMORE MD.

18 (a) Funeral director GEORGE WEBER & SON
(b) Address 2503 EDMONDSON AVE.

MAR 18 1947 (b) Edgar Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1947, at 11 A M

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to last death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mullis M.D.
Medical Examiner.
Date signed 3-17-47

VS 151

Exact age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49763

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55B

G49763 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3113 Belmont ave
(c) Hospital or institution: —16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3113 Belmont ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret M. Runkel

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife George L. Runkel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 11-1901

8. AGE: Years 46 | Months 0 | Days 2977 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name Charles N. Haigley
13. Birthplace Md

MOTHER
14. Maiden Name Mary A. Kelley
15. Birthplace Md

16 (a) Informant Mr. Geo. L. Runkel
(b) Address 3113 Belmont ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 20-47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md

18 (a) Funeral director Geo. L. Beyer Jr.
(b) Address 1512 Hollins St

19 (a) Date rec'd by registrar Mar 18 47 (b) Clayton Williams Registrar

VS 150 8 10

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 17 1947 at 4½ M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 19 1946 to Mar 16 1947 and that I last saw h[illegible] alive on Mar 16 1947.

Immediate cause of death Cardiac Thrombosis — Duration Wk

Due to Cancer bones — 9 Mos

Due to —

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. F. Hawkins M. D.

Address 1 E. Randall St Date signed 3/18/47

49764

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G49764 : 6 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1947 W Franklin St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1947 W Franklin St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Geo James Bond

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Emma
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 20 1862

8. AGE: Years 84 | Months 8 | Days 17 | If less than one day: hr. min.

9. Birthplace: London England (Town, county, and state)
10. Usual Occupation: Stock Clerk
11. Industry or business:

FATHER
12. Name: John Bond
13. Birthplace: London England

MOTHER
14. Maiden Name: Sarah Johnson
15. Birthplace: London England

16 (a) Informant: Mrs. Geo. C. Bond
(b) Address: 1718 Hollins Balto 27 Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/19/47 (month) (day) (year)
(c) Cemetery or crematory: Mt Olivet
Location: Baltimore Md

18 (a) Funeral director: Gilbert & Sons
(b) Address: 1214 E Fayette St

19 (Date rec'd by Registrar) MAR 19 1947 (Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1947, at 3:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/11 1947 to 3/16 1947 and that I last saw him alive on 3/16 1947

	Duration
Immediate cause of death: Myocarditis	3 yrs
Due to: Arteriosclerosis	
Due to: Arterial Sclerosis	
Other Conditions: Senility	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas O Leahy M.D.
Address 2145 W Balto St Date signed 3/18/47

G49765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G49765

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Type or write the causes of death clearly and legibly. Physicians: please write correct age, is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1205 John St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1205 John St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Belle Brown

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Frank S. Brown
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan 27 1879
8. AGE: Years 68 | Months 1 | Days 21 | If less than one day hr. min.
9. Birthplace Balto Co. Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name Benj. C. Khatzer
13. Birthplace Balto Co Md

MOTHER
14. Maiden Name Mary E. Gill
15. Birthplace Balto. Co. Md.

16 (a) Informant Mrs Helen Norris
(b) Address 1205 John St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 | 20 | 47 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location
18 (a) Funeral director Williams Cook Inc
(b) Address 1217 St. Paul St
19 (a) MAR 19 1947 (Date received by registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 17th 1947, at 2 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 2 21 1947, to 3 17 1947, and that I last saw her alive on 3 17 1947
Immediate cause of death Hypertension
Coronit - coronary thrombosis — Duration
Due to
Due to
Other Conditions Cardiac - Kidneys
(2) Pneumonia
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [illegible] M. D.
Address 1422 Park Ave Date signed 3 19 47

VS 150

G49766

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G49766 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 617 N. Mulberry St.
(c) Hospital or institution: 4'
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 617 N. Mulberry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Albert Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Negro	Married

6 (b) Name of husband or wife Lucy Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15, 1890

8. AGE: Years	Months	Days	If less than one day
57 56	-	2	hr. min.

9. Birthplace Waterbury, Md. (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Sam Johnson
13. Birthplace Waterbury, Md.

MOTHER
14. Maiden Name Cornelius Davis
15. Birthplace Lynchburg, Va.

16 (a) Informant Mrs. Lucy Johnson
(b) Address 617 N. Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-21-47 (month) (day) (year)
(c) Cemetery or crematory Crossroad
Location Waterbury, Md.

18 (a) Funeral director Charles R. Low
(b) Address 102 N. Addison Annapolis

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 19 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1947 at 8:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 25 1947 to March 17 1947 and that I last saw h. alive on March 17 1947.

Immediate cause of death	Duration
Coronary Heart Disease	7
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M.D.
Address 94 Duke St. Date signed 3/19/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The number of medical certificate should be carefully supplied.

G49767

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G49767

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 205 Augusta Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Towles Hant

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-05-4790

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Ruth E (Busic)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 13, 1891

8. AGE: Years	Months	Days	If less than one day
56 55	2	4	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business Gas & Elec. Co

FATHER
12. Name Harry T Hant
13. Birthplace Virginia

MOTHER
14. Maiden Name Florence Lee Dennison
15. Birthplace Virginia

16 (a) Informant Mrs Ruth E Hant
(b) Address 905 augusta Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 20 '47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave & Milton.

18 (a) Funeral director Harry H Wetzler
(b) Address 410 Edmondson Ave

19 (a) MAR 19 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1947 at 9:28 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to Generalized Arteriosclerosis.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D.
Medical Examiner.
Date signed 3-17-47

VS 151

G49768

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G49768

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 558 Oxford St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Albert Spragga

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Dora B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 24, 1867

8. AGE: Years	Months	Days	If less than one day
70	1	24	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Porter
11. Industry or business

FATHER
12. Name Andrew A. Spragga
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Frances Cook
15. Birthplace Baltimore, Md.

16 (a) Informant Dora B. Spragga
(b) Address 558 Oxford St.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 3-21-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location City

18 (a) Funeral director Samuel W. Sullivan Jr.
(b) Address 10 N. Arlington Ave

19 (a) MAR 19 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1947, at 9:55 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to Generalized Arterio-sclerosis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Gaw M.D. Medical Examiner.
Date signed 3-18-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

Huntington Williams M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49769

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered G49769

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3907 Pennsington Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3907 Pennington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katie Bylen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	M.

6 (b) Name of husband or wife John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years	Months	Days	If less than one day
49			hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name —
13. Birthplace Austria

MOTHER
14. Maiden Name —
15. Birthplace Austria

16 (a) Informant John Dylen
(b) Address 3907 Pennington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A. A. Co.

18 (a) Funeral director Wm. L. Fiallkowski
(b) Address 2007 Eastern Ave

19 (a) MAR 19 1947 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-17- 1947 at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-17- 1946 to 3-17 1947 and that I last saw he alive on 3-16- 1947

Immediate cause of death Pulmonary congestion — 4 Min.

Due to coronary disease 0

Due to Pneumonia — Asthma 4 mos.

Other Conditions + other complications

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature S. D. Guard M. D.
Address Medical Arts Bldg Date signed 3-17-47.

VS 150 Dr. L. Demarco Tex 6675

C 19770 106968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. C 19770

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3010 White Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Michael Suehle

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Ida Marie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21/1864

8. AGE: Years	Months	Days	If less than one day
82	8	26	hr. min.

9. Birthplace Europe
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Conrad Suehle
13. Birthplace Europe ?

MOTHER
14. Maiden Name Johanna ?
15. Birthplace Europe ?

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (b) Date thereof March 20th
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Comm
Location City

18 (a) Funeral director Welsh Funeral Home
(b) Address 2008 Orleans St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION 12.30 A.M.

20. DATE OF DEATH Mar.17/1947 19 at hospital

21. I certify that death occurred on the date above stated; that I attended deceased from Mar.7/47 19 to Mar.17 1947, and that I last saw him alive on Mar/17/ 19 47

Immediate cause of death	Duration
Pulmonary Abscess	
Due to	
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. Bowen Muffinann M. D.
Address Baltimore City Hosp. Date signed (21 Mar. 47)

VS 150 MAR 19 1947 Registrar Williams, M.D.

114 D

M. D. R. 1939-9

G497 74

HEALTH DEPARTMENT—CITY OF BALTIMORE

G49771

CERTIFICATE OF DEATH

131a

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. House Good Shepherd St. 19-4 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Amelia M. Strauss

(a) Residence: No. House Good Shepherd St., ... Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. Sex	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	Widow

5a. If married, widowed, or divorced: HUSBAND of (or) WIFE of Dr George A. Strauss

6. DATE OF BIRTH (month, day, year) June 20 - 1860

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
86	8	25 27	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Nurse

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or (State or country) Baltimore Md.

FATHER

13. NAME Anthony Strone

14. BIRTHPLACE (city or town) (State or country) Germany

MOTHER

15. MAIDEN NAME Dorothy Brandt

16. BIRTHPLACE (city or town) (State or country) Germany

17. INFORMANT Dr Fred Strauss

(Address) 4300 Hathland Av

18. BURIAL, CREMATION, OR REMOVAL

Place Loudon Park Date MAR 20 1947

19. UNDERTAKER Mr. & Mrs. John F. Gerfelo Son

(Address) 5311 Edmondson Ave

20. FILED ... 19... Huntington Williams Registrar

MAR 19 1947

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Mar. 17 1947

22. I HEREBY CERTIFY, That I attended deceased from July 16 1945 to Mar 17 1947

I last saw her alive on Mar 17 1947 Death is said to have occurred on the date stated above, at 7P m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
General Arteriosclerosis	
Mitral Regurgitation	
Chronic Interstitial Nephritis	10 yrs

Other contributory causes of importance:

Name of operation ... Date of ...

What test confirmed diagnosis? Necropsy Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ... 19...

Where did injury occur? ... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? No If so, specify ...

(Signed) J. A. Chatard M. D.

(Address) 1300 N. Calvert St. Balto 2 Md.

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G49772

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92a

Registered No. G49772

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days): 8 days
(e) Length of stay in Baltimore (yrs., mos., or days): 42 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 816 Union Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: Krixer, Ernest Edward

3 (b) If veteran, name war: WWI

3 (c) Social Security Account No.:

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lula Krixer

6 (c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): Oct. 26, 1889

8. AGE: Years: 57 Months: 4 Days: 20 If less than one day: hr. min.

9. Birthplace: Gettysburg, Pa.
(Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business:

FATHER
12. Name: John Krixer
13. Birthplace: Pa.

MOTHER
14. Maiden Name: Mary Steinour
15. Birthplace: Pa.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: March 22 - 1947 (month) (day) (year)
(c) Cemetery or crematory: Lorraine Park
Location: Baltimore Co. Maryland

18 (a) Funeral director: Burgee Funeral Home
(b) Address: 3631 Falls Road

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

VS MAR 19 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 18 19 47, at 12:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 10 19 47 to March 18 19 47 and that I last saw him alive on March 18 19 47

Immediate cause of death: Arteriosclerosis, aortic with aortic stenosis. — Duration: UNKNOWN

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: William A. Nelson M. D.
Address: Asst. Surgeon (R) Date signed: 3/18/47

G49773

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G49773 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street city
(c) Hospital or institution:
Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 85 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Clara Miller

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 2, 1861

8. AGE: Years	Months	Days	If less than one day
85	3	15	hr. min.

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation Mill Worker
11. Industry or business

FATHER
12. Name George Miller
13. Birthplace

MOTHER
14. Maiden Name Catherine Heuffman
15. Birthplace

16 (a) Informant Sisters of the Poor
(b) Address 1200 Valley Street city.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof MAR. 20 1937 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 East Biddle St

19 (a) MAR 19 1937 (Date received by Registrar) Huntington Williams, M.D.

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH Mch-17- 1937, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10- 1937, to Mch 17- 1937, and that I last saw her alive on Mch-17- 1937.

Immediate cause of death	Duration
Edema Lungs -	14 dy.
Due to Chronic Myocarditis	3 yrs
Due to	
Other Conditions Arteo-Sclerosis	5 Yrs

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E. North Ave Date signed 3/19/37

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49774

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

Reg. G49774

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 18 E RANDALL ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 18 E RANDALL ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES W. MUHLY

3 (b) If veteran, name war —

3 (c) Social Security Account No. 214-03-0275

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) JULY 4-1872

8. AGE: Years	Months	Days	If less than one day
74	8	11	hr. min.

9. Birthplace BALTIMORE MD
(Town, county, and state)

10. Usual Occupation CLERK.

11. Industry or business BURROWES BROS MFG Co.

FATHER
12. Name CHAS W. MUHLY
13. Birthplace GERMANY

MOTHER
14. Maiden Name HENRIETTA JACKEL
15. Birthplace GERMANY

16 (a) Informant MISS ANNA E MUHLY
(b) Address 18 E RANDALL ST

17 (a) BURIAL (b) Date thereof MARCH-21-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory BALTIMORE CEM.
Location BALTO MD

18 (a) Funeral director Wm Chas A & S Rohde
(b) Address 2327 Edmondson Ave

19 (a) MAR 19 (b) 1947
(Date rec'd by registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1947, at 1.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1942 to 3/18 1947 and that I last saw him alive on 3/18 1947

Immediate cause of death	Duration
(a) Pulmonary Edema	2 days
Due to (b) Mitral Insufficiency	6 mos
Due to (c) Arterial Hypertension	6 mos
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address 6279 Wellams Ave Date signed 3/19/47

Huntington Williams, M.D.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

G49775 BC# D78394 CERTIFICATE OF DEATH 157c Registered No. G49775

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mercy Hospital
(c) Hospital or institution: Calvert & Saratoga Sts.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2946 Cornwall Rd - 22
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Susan Shakespeare

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17, 1947

8. AGE: Years - | Months - | Days - | If less than one day — hr. 30 min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation ---

11. Industry or business

FATHER 12. Name Gilbert R. Shakespeare

13. Birthplace Baltimore

MOTHER 14. Maiden Name Irene M. Weston

15. Birthplace North Carolina

16 (a) Informant Mr. Gilbert R. Shakespeare

(b) Address 2946 Cornwall Rd. Balto. 22

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 3/19/47 (month) (day) (year)

(c) Cemetery or crematory Greenmount Crematory

Location Baltimore, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams M.D.

MAR 19 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/17/47 19 , at 7:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/17/ 1947 to 3/17/ 1947 and that I last saw h.e.r. alive on 3/17 19 47

Immediate cause of death: Defective Development — Duration

Due to: Arteriosclerosis Monster

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. Brunkenhank

Address Mercy Hospital Date signed 3/18/47 D.

X

G49776

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Reg. G49776

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3905 Fait Ave
(c) Hospital or institution:
26
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3905 Fait Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George C. Blatchamp

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-03-6235

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Theresa R. Blatchamp

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) April - 2 - 1884

8. AGE: Years	Months	Days	If less than one day
62	11	15	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Warehouseman

11. Industry or business Nat'l. Dentifrice Products

FATHER
12. Name Valentine Blatchamp
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Barbara Thiem
15. Birthplace Balto. Md.

16 (a) Informant Theresa R. Blatchamp
(b) Address 3905 Fait Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 - 20 - 47 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director John C. Miller Inc.
(b) Address 2439 E. Oliver St

19 (a) (Date rec'd by registrar) (b) Registrar

VS Form MAR 19 1947 Lustrigon Notarius, M.

MEDICAL CERTIFICATION

20. DATE OF DEATH March - 17 1947 at 2:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5 - 9 1944 to 3 - 17 1947 and that I last saw him alive on 3 - 17 1947

Immediate cause of death	Duration
Cerebral Hemorrhage	10 hrs
Due to Carcinoma of Liver	3 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 5-13-44
Major findings of operation: Inoperable Cancer of liver
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. J. Davidow M. D.
Address 3218 Eastern Ave Date signed 3-18-47

X

G49777

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 309

G49777.
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Keyser & Oakland
(c) Hospital or institution: W. G. G. H. 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1420 Hollins St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLARA VIRGINIA LANAHAN

3 (b) If veteran, name war -
3 (c) Social Security Account No. -

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife. Jeremiah Lanahan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 14, 1869

8. AGE: Years 77 | Months 5 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Christian Briel
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Hartman
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Grace E. Kissick
(b) Address 1410 W. Lombard St.

17 (a) Burial (b) Date thereof 3/19/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 19 1947 Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/17 1947 at 2310 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/6 1947 to 3/17 1947.
and that I last saw h[illegible] alive on 3/17 1947.

	Duration
Immediate cause of death: Cardiac Resp. Failure	
Due to: Bronchopneumonia & Edema	2 wks.
Due to: Pneumonia - Rt Lt Lobe	2 wks
Other Conditions: Fatal Hemorrhage	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature W. B. Peasley M.D.
Address W. G. G. H. Date signed 3/19/47

VS 150

108

G49778

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G49778

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3014 Baker St.
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3014 Baker St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME AUGUST A. WEBER

3 (b) If veteran, name war: no
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Married

6 (b) Name of husband or wife: Marie Eliz. Weber (nee Oebbecke) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1881

8. AGE: Years	Months	Days	If less than one day
65	3	25	hr. min.

9. Birthplace Philadelphia, Pa. (Town, county, and state)
10. Usual Occupation Collection Manager
11. Industry or business

FATHER
12. Name Charles Weber
13. Birthplace Germany

MOTHER
14. Maiden Name - Manz
15. Birthplace Germany

16 (a) Informant Mrs. Marie Weber
(b) Address 3014 Baker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 19 1947 (Filed by registrar) (b) Municipal Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17, 19 47 at 7:30a M

21. I certify that death occurred on the date above stated; that I attended deceased from February 19 45 to March 17 19 47 and that I last saw him alive on 3-17 19 47.

Immediate cause of death	Duration
Cerebral Hemorrhage	10 days
Due to Hypertension & Atherosclerosis	3 yrs. 2 yrs.
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Guy Coleman M. D.
Address 1201 Eutaw Street Date signed 3-18-47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49779

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G49779 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1610 Poplar Grove St.
(c) Hospital or institution:

15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1610 Poplar Grove St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: ANNA MARIE GERBER

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Joseph Gerber
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Oct. 3, 1855

8. AGE: Years	Months	Days	If less than one day
91	5	15	hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Carl Epp
13. Birthplace: Germany

MOTHER
14. Maiden Name: Annie M. Rohr
15. Birthplace: Germany

16 (a) Informant: Mrs. Anna M. Little
(b) Address: 1610 Poplar Grove St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/21.47 (month) (day) (year)
(c) Cemetery or crematory: Holy Cross Cem.
Location: Brooklyn, Md.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) MAR 19 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1947 to Mar 18 1947 and that I last saw h/ alive on Mch 18 1947

Immediate cause of death: Chronic Cardio Vascular dis — Duration: 9

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Grant W. Kalm M. D.
Address 1731 Pop Gr St Date signed 3/19/47

VS 150

X

3 Copies G49780

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G49780 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1820 E. Biddle St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 M
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1820 E. Biddle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALFRED BROWN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1. 1887

8. AGE: Years	Months	Days	If less than one day
59	9	15	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name William P. Brown
13. Birthplace Md

MOTHER
14. Maiden Name Lizzie Rodgers
15. Birthplace Smithfield Md

16 (a) Informant Della Williams
(b) Address 1820 E. Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/19/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location Balto. Co. Md.

18 (a) Funeral director Robert E. Williams
(b) Address 515 McElderry St.

19 (a) (Date received by Registrar) MAR 19 1947 (b) Huntington for W. Lewis, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16, 1947, at 1.20 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic heart disease.
Cerebral edema.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Geo. G. Merrill M.D. Medical Examiner.
Date signed 3-17-47

G49781

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G49781 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 563 Lawrens St.
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 563 Lawrens St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lelia B. Amy

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4 Sex: Female | 5 Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife James E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1, 1880

8. AGE: Years 67 | Months 6 | Days 16 | If less than one day hr. min.

9. Birthplace King & Queen Co. Va. (town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Edward Brown
13. Birthplace King & Queen Co. Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mr. James E. Amy
(b) Address 563 Lawrens St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/19/1947 (month) (day) (year)
(c) Cemetery or crematory Greenmount Mem. Park
Location Baltimore, Md.

18 (a) Funeral director Mr. George A. Hallard
(b) Address 1631 Druid Hill Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS 19 MAR 19 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/17 19 47, at 6:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 13 1947 to March 17 1947 and that I last saw h alive on March 17 19 47

Immediate cause of death Cardio-Vascular Renal Disease — Duration 1 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. H. Wurtz

Address 515 E. Lanvale Date signed 3/19/47 M. D.

X

Dup Copy G49782

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G49782

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4601 Asbury Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4601 Asbury Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Frederick Lutcke-Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12-1891

8. AGE: Years	Months	Days	If less than one day
56	1	5	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Dept of Education
11. Industry or business Balto Md.

FATHER
12. Name Louis Lutcke
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Miller
15. Birthplace Md.

16 (a) Informant Mrs. Elizabeth Lutcke
(b) Address 4601 Asbury Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-20-47 (month) (day) (year)
(c) Cemetery or crematory Oaklawn
Location Balto.

18 (a) Funeral director Leonard D. Ruck
(b) Address 5305 Harford Rd.

19 (a) MAR 19 1947 (Date filed by registrar) (b) Registrar's No. 4 William H...

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-17- 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 25 1946, to Mar 17 1947 and that I last saw h[illegible] alive on Mar 16 1947.

Immediate cause of death	Duration
Coronary Occlusion	2 hrs
Myocardial Insufficiency	2 hrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leo D'Lyppy M. D.
Address 4201 Patterson Pk Ave Date signed 3/17/47

VS 180

G49783 13th B 63320

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157a

G49783 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 4 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4628 Harcourt Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Diane Eileen Lewis

3 (b) If veteran, name war:

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/28/46

8. AGE: Years	Months	Days	If less than one day
	3	19	hr. min.

9. Birthplace Balto, Md. (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Hayden Lewis
13. Birthplace England

MOTHER
14. Maiden Name Mary Vaugh Jones
15. Birthplace Rome, N.Y.

16 (a) Informant Mr Hayden Lewis
(b) Address 4628 Harcourt Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/19/47 (month) (day) (year)
(c) Cemetery or crematory Moreland Pk.
Location Balto -d

18 (a) Funeral director Leonard J. Luck
(b) Address 5305 Harford Road

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MAR 10 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/17 1947, at 4 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/30 1946 to 3/17 1947. and that I last saw h ck alive on 3/17 1947

Immediate cause of death	Duration
Respiratory Failure	
Due to Hydrocephalus	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul H. Stiller Jr.
Address Mercy Hospital Date signed 3/17/47

X

G49784

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G49784 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 917 N. Luzerne Avenue (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** John George Smith Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of ~~husband~~ or wife Alvina (nee Creamer)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 26, 1897

8. AGE: Years	Months	Days	If less than one day
50	-	19	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Chauffer
11. Industry or business Sydenham Hospital

FATHER
12. Name Herman Smith
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Anna Schmisser
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Alvina Creamer Smith
(b) Address 917 N. Luzerne Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/47 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Baltimore National
Location Frederick Rd. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) 10 1947 (Filed by registrar) (b) Thurlington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1947 at 9 55 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George E. Merrill M.D. Medical Examiner.
Date signed 3/18/47

X

G49785

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1639

G49785
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2620 Mc Elderry St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Andrew Hunter

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-03-3131

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of ~~husband~~ or wife: Mary (nee Steck)
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): March 18, 1896

8. AGE: Years	Months	Days	If less than one day
51	-	-	hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business: Rustless Iron & Steel

FATHER
12. Name: Mathew Hunter
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Mary Connors
15. Birthplace: Ireland

16 (a) Informant: Mrs. Mary Steck Hunter
(b) Address: 2620 McElderry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/47 (month) (day) (year)
(c) Cemetery or ~~crematory~~: Parkwood Cemetery
Location: Taylor Ave. Baltimore, Md.

18 (a) Funeral director: Charles E. Schimunek
(b) Address: 2601-03 E. Madison Street

19 (a) (Date received by Registrar) (b) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1947, at 2:25 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Cyanide Poisoning

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-18-47 at 1:30 P.M.
(b) Where did injury occur? 2620 Mc Elderry St
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Ingestion of Cyanide

23. Signature: Earl F. Royer M.D.
Medical Examiner.
Date signed 3-18-47

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49786

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G49786 / 1248 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Dr. Beck's Institution 71
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2424 E. Madison Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCES VLCEK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or ~~wife~~ Louis Vlcek
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23, 1905

8. AGE: Years	Months	Days	If less than one day
41	8	23	hr. min.

9. Birthplace Czechoslovakia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Louis Vlcek - husband
(b) Address 2424 E. Madison St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/19/47 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Oak Hill
Location Horner's Lane, Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison St.

MAR 19 1947 (b) [illegible]
(Registered by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1947 at 6:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 17 1947 to March 16 1947 and that I last saw h[illegible] alive on March 16 1947.

Immediate cause of death	Duration
Congestive heart failure	2 Dys
Due to Portal Cirrhosis	4 Mos.
Due to Splenomegaly - Portal Thrombosis	2 mos
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harvey G Beck M. D.
Address 100 E 23rd St Date signed 3-24-47

VS 150

every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the

G49787

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G49787 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 922 N. Madeira Street
(c) Hospital or institution: 713
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 922 N. Madeira Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANNA HAJEK

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Bohumil Hajek
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 19, 1876

8. AGE: Years	Months	Days	If less than one day
71 69	1	29	hr. min.

9. Birthplace Czechoslovakia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Bubenik
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Katherine Jenista
15. Birthplace Czechoslovakia

16 (a) Informant
(b) Address 922 N. Madeira Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/47 (month) (day) (year)
(c) Cemetery or crematory ~~XXXX~~ Oak Hill
Location Horner's Lane, Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) MAR 18 1947 (b) [illegible] registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1947, at 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from February 1 1947, to March 17 1947, and that I last saw h[illegible] alive on March 17 19 47

Immediate cause of death	Duration
Pulmonary Edema	3/16/47
Due to C. Myocarditis	2/1/47
Due to Hypertension Cardio Vascular Disease	2/1/43
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Rymer M. D.
Address 801 S. Kenwood Date signed 3/19/47

G49788

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

G49788 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 311 Fort Hillave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto City (If outside city or town limits, write RURAL and give town)
(d) Street No. 311 Fort Hill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Elizabeth Tarum.

3 (b) If veteran, name war / 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. widowed.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 15 1871

8. AGE: Years 75 | Months 7 6 | Days 2 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business Home

FATHER 12. Name Louis J Tarum.
13. Birthplace Maryland.

MOTHER 14. Maiden Name Mary Keetz
15. Birthplace Germany

16 (a) Informant Helen A Hockard
(b) Address 311 Fort Hill ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balt Co

18 (a) Funeral director Luc I May Nebb
(b) Address Catonsville Md

MAR 19 1947 (Date received by registrar) (b) Washington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 19 at 5-00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1946 to March 17 1947 and that I last saw her alive on March 16 1947

Immediate cause of death: starvation acidosis — Duration: 2 weeks

Due to: Carcinoma, metastatic of rectum — 2 years

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan Rosen M. D.
Address 206 S. Gilmor st Date signed 3-18-47

VS 2

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49789

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G49789 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
South Baltimore General Hospital.
D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Michigan (b) County Pontiac
(c) City or town.....
(If outside city or town limits, write RURAL and give town)
(d) Street No. 166 Bondale St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME ANDREW P. CULLEN

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Mande
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12, 1884

8. AGE: Years	Months	Days	If less than one day
62	9	6 4	hr. min.

9. Birthplace Philadelphia, Pa.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Thomas Cullen
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Mulholland
15. Birthplace Philadelphia, Pa.

16 (a) Informant Alice Cullen (sister)
(b) Address Gloucester, N. J.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3-29-47 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Gloucester, N. J.

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul St.

19 (a) [illegible] (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16, 1947 at 2.45 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?.....
(d) Means of injury.....

23. Signature 3-17-47 George A. Merrill M.D.
Medical Examiner.
Date signed.....

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Registered Baltimore, Md. MAR 19 1947

VS 151

G49790
CWE-107353

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓107

Registered No. G49790

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
2- 12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1810 (1810) E. Pratt Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Schmidt

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Louis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23-1866

8. AGE: Years 80 | Months 9 | Days 24 25 | If less than one day ... hr. ... min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Albert
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Breden
15. Birthplace Virginia

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location

18 (a) Funeral director Edwin F. Hoffman
(b) Address 1639 Broadway

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 MAR 19 1947

Huntington Hillen

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1947, 5:13 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 5 1947, to Mch. 17 1947, and that I last saw her alive on Mch. 17 1947.

Immediate cause of death	Duration
Bronchial pneumonia	2 weeks
Due to	
Due to	
Other Conditions Arterio sclerosis gen	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. Rosell Huffman M. D.
Address Baltimore City Hosp. Date signed Mch 19 47

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1576

G49791 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State N. J. (b) County.....
(c) City or town Roselle (If outside city or town limits, write RURAL and give town)
(d) Street No. 6 Grant St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Martin Plasca

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 7-3-46

8. AGE: Years | Months: 8 | Days: 16 | If less than one day: ..... hr. ..... min.

9. Birthplace N. J. (Town, county, and state)

10. Usual Occupation.....

11. Industry or business.....

FATHER 12. Name Russell Plasca

13. Birthplace N. J.

MOTHER 14. Maiden Name Cinth Christadora

15. Birthplace N. Y.

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 3/19/47 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory.....
Location Roselle N. J.

18 (a) Funeral director Luna J. Silkman & Son
(b) Address Main & Locust Sts. Roselle Boro

19 (a) MAR 19 1947 (b) Huntington W. Va. M.D.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1947 at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 9 1947 to Mar. 19 1947 and that I last saw him alive on Mar. 19 1947.

Immediate cause of death: Congenital Heart disease
Cyanotic group

Due to.....

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature Herbert Thompson M. D.
Address Johns Hopkins Hosp. Date signed 3-19-47

G49792

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G49792 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cause is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 Pontiac Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 100 Pontiac Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Clement Floyd

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 215-07-7881

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Ann Floyd

6 (c) If alive, give [illegible]

7. Birth date of deceased (mo., day, yr.): May [illegible]

8. AGE: Years 65 | Months 9 | Days 26 | If less than one day ____ hr. ____ min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual Occupation: Retired Electric Welder

11. Industry or business: Davnson Chemical Co

FATHER
12. Name: George W. Floyd
13. Birthplace: Baltimore Md

MOTHER
14. Maiden Name: Jennie Stevens
15. Birthplace: Baltimore Md

16 (a) Informant: Mrs Gertrude Floyd
(b) Address: #3 Talbott St - 25 -

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/47 (month) (day) (year)
(c) Cemetery or crematory: Cedar Hill
Location: Gov. Ritchie Highway

18 (a) Funeral director: Milton Schilling
(b) Address: 3914 Hanover St - 25 -
Signature or address of person acting for Williams, Registrar

APR 19 1947
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17th 1947 at 8.30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/7/1946 to 3/17/1947 and that I last saw him alive on 3/17/1947.

Immediate cause of death	Duration
Coronary thrombosis with angina syndrome	4 mos.
Due to	
Due to	
Other Conditions Cerebral and general arterio sclerosis (Include pregnancy within 3 months of death)	?

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Harry Deibel M. D.
Address 1226 Hanover St. Date signed 3/18/1947

G49793

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G49793

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Montgomery
(c) City or town Rockville R D 4
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuella Blaney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1, 1939

8. AGE: Years	Months	Days	If less than one day
8	2	18	hr. min.

9. Birthplace Rockville Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Samuel Blaney
13. Birthplace Rockville Md

MOTHER
14. Maiden Name Edythe Walker
15. Birthplace Pittsburg

16 (a) Informant Mrs Blaney
(b) Address Rockville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Rockville Md

18 (a) Funeral director H Wood Watts
(b) Address Silver Spring Md

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MAR 19 1947
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 Mar 47 19 , at 10:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 16 Mar 1947 to 19 Mar 1947, and that I last saw h alive on 19 Mar 1947.

Immediate cause of death: Convulsions — Duration
Due to: Cause unknown
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert B. Bowen M D
Address Univ. Hospital Date signed 19 Mar 47

X

G19794

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937 Registered No. G49794

Baltimore City

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Anchorage # 1 Curtis Bay
(c) Hospital or institution: Guarantee Station
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 25

2. USUAL RESIDENCE OF DECEASED:
(a) State England (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Austin Neame - O.J.M.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Selia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9, 1874

8. AGE: Years	Months	Days	If less than one day
O.J.M. 72	9	17	hr. min.

9. Birthplace Sutton Surrey, England (Town, county, and state)

10. Usual Occupation Timber Merchant

11. Industry or business Glenkstin

FATHER
12. Name Austin Neame
13. Birthplace England

MOTHER
14. Maiden Name
15. Birthplace England

16 (a) Informant Selia Neame
(b) Address England

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) [illegible] (Date received by Registrar)

VS 191 2/27/47 [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH February 26 1947, at 8 00 AM

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William L. Helfrich M.D. Medical Examiner.
Date signed 26 Feb 47

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49795

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G49795
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette Johns 14
(c) Hospital or institution: Womens Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 88 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1405 W. Royal Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Caroline Miller Reese

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: Single
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 10 May 1858

8. AGE: Years 88 | Months 10 | Days 8 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None
11. Industry or business

FATHER
12. Name Henry Reese
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Mary Anne Miller
15. Birthplace Alexandria, Va.

16 (a) Informant Mabel M. Reese (sister)
(b) Address 1405 W. Royal Ave, Baltimore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-20-47 (month) (day) (year)
(c) Cemetery or crematory Friends Cemetery
Location Harford Av. city

18 (a) Funeral director Stewart Morgan Co.
(b) Address 108 W. Mt. Ave.

19 (a) ____ (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS MAR 19 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 March 1947, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 16 Mar 1947, to 18 Mar 1947, and that I last saw HER alive on 15 Mar 1947.

Immediate cause of death	Duration
Cardio Respiratory Failure	
Due to Cerebral hemorrhage	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter Buckner M. D.
Address Womens Hospital Date signed 18 Mar 47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

325.70

G49796

509378

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 307

G49796 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 41 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1002 N. Gt. Dough St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Horace Godsey ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced
Male	Black	Married

6 (b) Name of husband or wife Edna Godsey
6 (c) If alive, give age 50 yrs

7. Birth date of deceased (mo., day, yr.) 2-2-90

8. AGE: Years	Months	Days	If less than one day
57 56			hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Stevedore
11. Industry or business Shipping
FATHER 12. Name Floyd Godsey
13. Birthplace Va
MOTHER 14. Maiden name Henrietta Morgan
15. Birthplace Va
16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Buried (Burial, cremation, or removal) (b) Date thereof March 21 47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem. Location B. A. County Md
18 (a) Funeral director The Cliff Sellers Co Inc.
(b) Address 1129 N. Carlton St.
19 (a) (Date received by Local Registrar) MAR 19 1947 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1947 3:25 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 4-47 19 to March 18-47 and that I last saw deceased alive on March 18-1947
Immediate cause of death Cerebral embolus — Duration 6 hrs
Due to Pneumococcal endocarditis — 2 mo
Due to Syphilitic aortic valve disease
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Robert E. Mason M. D.
Address Johns Hopkins Hosp Date signed 18 Mar 47

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

49797

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 49797

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2402 E. Federal St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2402 E. Federal St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha M. Cullison

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Weston L. Cullison

6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) March 3 1880

8. AGE: Years 67 | Months | Days 16 15 | If less than one day ___ hr. ___ min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Geo. W. Bourne
13. Birthplace Md.

MOTHER
14. Maiden Name Annie H. Slater
15. Birthplace Balto. Md.

16 (a) Informant Weston L. Cullison
(b) Address 2402 E. Federal St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-22-47 (month) (day) (year)
(c) Cemetery or crematory Balto Memorial
Location North Ave.

18 (a) Funeral director Geo. C. Miller & Son
(b) Address 2437 E. Oliver St

19 Filed MAR 19 1947 Registered by Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/19/47 19 , at 1:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/28 1947 to 3/19 1947 and that I last saw h[illegible] alive on 3/17 1947.

Immediate cause of death Broncho pneumonia — Duration 48 hrs.

Due to Hypertension & C.V. Disease — 5 years

Chronic Nephritis — 3 years

Due to

Other Conditions Arthritis — ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Max Bauer M.D.
Address 1501 N. Milton Ave Date signed 3/19/47

correct age is especially important. Physicians: please write the

G19798

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (1937)

Registered No. G49798

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore Co. (If outside city or town limits, write RURAL and give town)
(d) Street No. 229 Murdock Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME BROWER JOHN B.

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-07-7691

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife ETHEL B ROWER
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) JAN 10 1893

8. AGE: Years	Months	Days	If less than one day
54	2	9	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business Maintenance

FATHER 12. Name John B. BROWER
13. Birthplace Pa.

MOTHER 14. Maiden Name Isabella Bowman
15. Birthplace Pa.

16 (a) Informant Ethelinda Brower
(b) Address 229 Murdock Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville, Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St

19 (a) MAR 20 1947 (Date received) Registrar Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 8 1947 to March 19 1947 and that I last saw h. alive on March 19 1947.

Immediate cause of death	Duration
Respiration failure	
Due to Arteriosclerotic Heart Dis.	1½ yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph I. Pearce M. D.
Address Union Mem. Hospital Date signed March 19, 1947

VS 150

G43799

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 146 B

Registered No. G43799

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Olive + Caroline
(c) Hospital or institution St. Joseph Hosp. 7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County [illegible]
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 508 N. Robinson (If rural, give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country [illegible]

3 (a) FULL NAME Gustaf A. Lund

3 (b) If veteran, name war W

3 (c) Social Security Account No. 213-01-2001

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/13/74

8. AGE: Years 73 | Months - | Days 6 | If less than one day hr. min.

9. Birthplace Sweden (town, county, and state)

10. Usual Occupation Retired

11. Industry or business Carpenter

FATHER 12. Name (Unknown) Lund

13. Birthplace Sweden

MOTHER 14. Maiden Name "

15. Birthplace "

16 (a) Informant Lillian E. Kudzma

(b) Address 508 N. Robinson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/47 (month) (day) (year)

(c) Cemetery, or crematory Oak Lawn

Location Eastern Ave. Extended

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St.

19 (a) MAR 20 1947 (Date received by local registrar) Huntington Williams, M. D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 19 1947, at 4 05 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/13/1947 to 3/19/1947, and that I last saw him alive on 3/19/1947.

Immediate cause of death Cardio-respiratory failure — Duration

Due to Uremia

Due to Chronic bilateral Nephritis

Other Conditions CA of Stomach

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard H. Young M. D.

Address St. Joseph Hosp. Date signed 3/19/47

1312

G49800

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G49800 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2605 Reisterstown Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2605 Reisterstown Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arron Louis Rothstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Late Ray
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years	Months	Days	If less than one day
82			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business Retired

FATHER
12. Name Harris Rothstein
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah ?
15. Birthplace Russia

16 (a) Informant Miss Mary Rothstein
(b) Address 2605 Reisterstown Road

17 (a) Burial (b) Date thereof March 20. 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bnai Israel Cemetery
Location Southern Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) MAR 20 1947 Huntington Williams, M.D.
(Date received) Registrar

MEDICAL CERTIFICATION 2.15

20. DATE OF DEATH March 18 1947 at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1945 19 to 3/18/47 19
and that I last saw h[illegible] alive on 3/18 1947

Immediate cause of death	Duration
Carcinoma of Stomach	18 Mos
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 2404 Druid Hill Ave Date signed 3/19/47

VS 150

X

G19801 B-109232

BALTIMORE CITY HEALTH DEPARTMENT,

CERTIFICATE OF DEATH

Registered No. G19801

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1430 E. Monument St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Richard Baker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Martha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1881

8. AGE: Years 65 | Months 6 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER
12. Name John Baker (D
13. Birthplace N.C.

MOTHER
14. Maiden Name Mary Harrison (D
15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/23/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. County, Md.

18 (a) Funeral director Joseph B. Locke, Jr.
(b) Address 304 N. Central Ave. Huntingtown Williams, Md.

19 (a) MAR 20 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1947, at 10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-17- 1947 to 3-18 1947, and that I last saw him alive on 3-18 1947.

Immediate cause of death	Duration
Bacterial Pneumonia	9 days.
with Multiple Abscesses + Septicemia	
Due to	
Due to	
Other Conditions Diabetes mellitus, Pulmonary Tuberculosis (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: Signed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Hunt
Address Balt. City Hosp. Date signed 3-19-47

VS 150

109

Please write clearly in ink. Information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49802

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G49802 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1325 N. CAROLINE St
(c) Hospital or institution: 8

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1325 N. CAROLINE ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FANNIE A. JONES

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C.	widow

6 (b) Name of husband or wife LEWIS (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAR. 4, 1873

8. AGE: Years	Months	Days	If less than one day
74	.	13	hr. min.

9. Birthplace BALTIMORE, Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ANDREW JONES
13. Birthplace Md

MOTHER
14. Maiden Name FRANCIS ANN JONES
15. Birthplace Md

16 (a) Informant CORA M. PINKETT
(b) Address 1325 N. CAROLINE St.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3/20/47 (month) (day) (year)
(c) Cemetery or crematory ARBUTUS MEM. PK
Location

18 (a) Funeral director Joseph B. Forfa, Jr.
(b) Address 1364 N. Central Ave

19 (a) MAR 20 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-17 1947 at 3 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 17 1947 to March 17 1947 and that I last saw h[illegible] alive on 3-17 1947.

Immediate cause of death	Duration
Congestive Heart Failure.	3 Days
Due to Arteriosclerotic Heart Disease	
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature F. K. Adams M. D.
Address 1222 N. Carrollton Ave. Date signed

VS 150

X 3-19-47

G49803 DC#B 69576

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √64

G49803 Registered No.

Write the causes of death clearly and legibly. Physicians: please write the age if infancy important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 14-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) DIA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1914 Division St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Queen

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/3/47

8. AGE: Years | Months: 2 | Days: 14 | If less than one day: 13 hr. min.

9. Birthplace Balto - Md (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Frank Queen
13. Birthplace Md

MOTHER
14. Maiden Name Violet Boswell
15. Birthplace Md

16 (a) Informant Violet Queen
(b) Address 1914 Division St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/20/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. H. Kelly
(b) Address 1303 Pleasant St

19 (a) (b)
(Date rec'd by registrar) Registrar
MAR 20 1947 Washington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1947, at 2:45 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Status thymicolymphaticus

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D.
Medical Examiner.
Date signed 3-17-47

X

G49804

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G49804

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1224 Washington Blvd
(c) Hospital or institution:
21
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
2
(d) Street No. 1224 Washington Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Grace Avara ✓

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Gregory
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years 53 | Months | Days | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Salvatore Maggio
13. Birthplace Italy

MOTHER
14. Maiden Name Giovannina Vinzini
15. Birthplace Italy

16 (a) Informant Rose Amino
(b) Address 556 Rolling Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 21 1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Old Frederick Road

18 (a) Funeral director Joseph Farace Inc
(b) Address 2013 Greenmount Ave

19 (a) (b) Registrar

MAR 20 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1947 at 1:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 13 1946 to March 1947 and that I last saw h[illegible] alive on March 18 1947.

Immediate cause of death: Bronchopneumonia — Duration: 9 days
Due to: Parkinsons Disease — 8 years
Due to:
Other Conditions: Atrophy Cerebellar right breast & bone — 6 yrs.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

(Signature) John O Urbach Jr. M. D.
Address 1227 Madison Blvd Date signed 3/14/47

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49805

BALTIMORE CITY HEALTH DEPARTMENT — Dr Browne

CERTIFICATE OF DEATH

Registered No. G49805

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1621 Millinman St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1621 Millinman St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Celestine Saunders

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Col

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15 1879

8. AGE: Years 67 | Months 6 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Alonza Erney
13. Birthplace Trinidad West Indies

MOTHER
14. Maiden Name Mary Wilson
15. Birthplace Md

16 (a) Informant Eva Banton
(b) Address 1105 N. Carolina St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-20-47 (month) (day) (year)
(c) Cemetery or crematory MY Auburn
Location Balto

18 (a) Funeral director Rayner Saunders
(b) Address 1412 E. Preston St

19 (a) (Date rec'd by registrar) MAR 20 1947 (b) Signature for Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 17 1947 at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-15 1946 to 3-17 1947 and that I last saw her alive on 3-15 1947

Immediate cause of death: hypertensive cardio-renal disease (uremia) — Duration: 5 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Rayner Browne M.D.

Address 1312 E. Madison St Date signed 3-19

Rayner Browne X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49806

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G49806 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1524 N Caroline St.
(c) Hospital or institution: *********
(d) Length of stay in hospital or inst. (yrs., mos., or days) **
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1524 N Caroline St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) ***
If yes, name country

3 (a) FULL NAME Margaret Ann Ackenback

3 (b) If veteran, name war *****
3 (c) Social Security Account No. *****

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: George Ackenback
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 5 1865

8. AGE: Years 81 | Months 4 | Days 15 14 | If less than one day: hr. min.

9. Birthplace: Baltimore Md (Town, county, and state)
10. Usual Occupation: At Home
11. Industry or business

FATHER
12. Name: Martin Hanrahan
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Ellen Scaleon
15. Birthplace: Ireland

16 (a) Informant: Mrs Alice Swift (Daughter)
(b) Address: 1524 N Caroline ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 /22/ 47 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral Cem.
Location: Old Fredrick Rd Baltimore Md.

18 (a) Funeral director: J. Melville Jenkins.
(b) Address: 2713 Kirk Ave Baltimore Md.

19 (a) Filed MAR 20 1947 (b) Huntington Williams, M.D. Registrar

VR 189

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 March 1947, at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8 January 1947, to 19 MARCH 1947, and that I last saw her alive on 18 MARCH 1947

Immediate cause of death	Duration
Acute Heart Failure	1 Hour
Due to Hypertension	8 years
Due to Arteriosclerosis	8 years
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Michael J. Dausch M. D.
Address 1 W. Oneida Ave. Date signed 3/19/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The

AB-107493 G49807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 587

Registered No. G49807

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mos.- 7days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1137 S. Sharp St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Felder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28- 1938

8. AGE: Years 8 | Months 9 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Quincy Felder
13. Birthplace S.C.

MOTHER 14. Maiden Name Anna May Porter
15. Birthplace S.C.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto Co. Md

18 (a) Funeral director Isaiah G. Brown Mar
(b) Address 1058 W Montgomery St

19 (a) (Date rec'd by registrar) (b) Huntingtown (City or town) Williamsport Md

VS MAR 20 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1947, at 10:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-10 1947, to 3-17 1947, and that I last saw her alive on 3-17 1947.

	Duration
Immediate cause of death: Cardiac insufficiency	3 da
Pulmonary Edema	3 da
Due to Rheumatic heart disease	6 mos
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wilson E. Hughes M.D.
Address Balto City Hosp Date signed March 19 1947

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49808

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G49808

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3000 Reisterstown Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-
(e) Length of stay in Baltimore (yrs., mos., or days) to dte.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3000 Reisterstown Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs PHILLIPS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) -1879

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Israel -
13. Birthplace Poland

MOTHER
14. Maiden Name Martha -
15. Birthplace Poland

16 (a) Informant Louis Phillips
(b) Address 3000 Reis Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-20-47 (month) (day) (year)
(c) Cemetery or crematory Holeman Herring Inc
Location Brantley's Lane

18 (a) Funeral director Jack Levin Inc
(b) Address 16 E. Balto. St

19 (a) MAR 20 1947 (b) Huntington Williamsville
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-19-47 1947 at 5A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/10 1947 to 3/18 1947 and that I last saw h. alive on March 18 1947.

Immediate cause of death Acute Pulmonary Edema — Duration 24 hours

Due to Myocardial Disease (Chronic) — Duration 2 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Buendler M. D.
Address 170 E. Fayette St Date signed 3/19/47

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49809

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 182B

✓ G49809 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore Gen Hosp. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 422 E. 22½ Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** William Edward Henry (William Henry)

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-14-9231

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6, 1913

8. AGE: Years	Months	Days	If less than one day
33	9	12	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Laborer - S

11. Industry or business Wholesale Houses, Inc.

FATHER
12. Name Robert Henry
13. Birthplace Vienna, Md

MOTHER
14. Maiden Name Amelia Gorman
15. Birthplace Calvert Co. Md

16 (a) Informant Ruth Pettus (Henry)
(b) Address 422 - E. 22½ St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Robert L. Young
(b) Address 1216 W. Caroline St.

19 (a) MAR 20 1947 (Date received by Registrar) (b) Huntington for Baltimore, Md.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1947, at 3:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to

Other Conditions Fractures Both Clavicles, 1-6 Ribs Rt. 1-2 Ribs left.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-18-47 at 2:30 P.M. 28/4
(b) Where did injury occur? Chapel Gate 4 Old Frederick Rd
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial Place While at work? yes
(d) Means of injury Mechanical Suffocation - Dirt Cave-in

23. Signature Earl L. Young M.D. Medical Examiner

Date signed 3-18-47

X

G49810

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G49810

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1122 Wilmer Crt
(c) Hospital or institution:

17-47

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 1122 Wilmer Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elnora Stephens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-2-1908

8. AGE: Years 38 | Months 5 | Days 16 | If less than one day hr. min.

9. Birthplace Lexington Va
(Town, county, and state)

10. Usual Occupation House Work

11. Industry or business

FATHER 12. Name John Broles Va

13. Birthplace

MOTHER 14. Maiden Name Minnie ?

15. Birthplace Va

16 (a) Informant Samuel L Stephens

(b) Address 1122 Wilmer Court

17 (a) SHIPPED (Burial, cremation, or removal) (b) Date thereof 3 20 47 (month) (day) (year)

(c) Cemetery or crematory EVERGREEN CEM-
Location LEXINGTON VIRGINIA

18 (a) Funeral director Williams & Jackson

(b) Address 916 Pennsylvania ave

19 (a) (Date received by Local Registrar) (b) MAR 20 1947

Funeral for Wednesday PM

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1947, at 12:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-14 1947 to 3-18 1947 and that I last saw her alive on 3-17 1947.

Immediate cause of death Coronary Thrombosis — Duration 4 Days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Atwell Jones M. D.

Address 5534 Dolfield Date signed 3-19-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G49811

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address March 17, 1947
(c) Hospital or institution:
530 N Gilmore st.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 530 N. Gilmor St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harrison Chamberlain

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-14-1895

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Rebecca

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6, 1893

8. AGE: Years	Months	Days	If less than one day
53	9	11	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Harrison Chamberlain
13. Birthplace Newport News Va

MOTHER
14. Maiden Name Jennie Lee
15. Birthplace Virginia

16 (a) Informant Rebecca Chamberlain
(b) Address 530 N. Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 21, 1947 (month) (day) (year)
(c) Cemetery or crematory Arlington Memorial
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Schroeder St

19 (a) (Date rec'd by registrar) (b) Wilmington

VS 250 MAR 20 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/17/1947, at 6:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/15 1947 to 3/17 1947, and that I last saw h alive on 3/14 1947.

Immediate cause of death	Duration
Pulmonary Edema	
Due to Cerebral Hemorrhage	
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. P. Harvell M. D.
Address 1600 N. Carrollton Ave Date signed 3/20/47

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49812

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1372

G49812 Registered No.

PRINT in PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution:
Mercy Hosp. 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23d.
(e) Length of stay in Baltimore (yrs., mos., or days) Life 68 Y.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto 31
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1930 Orleans St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Ford

3 (b) If veteran, name war	3 (c) Social Security Account No.
?	?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Black	Married

6 (b) Name of husband or wife Mamie D. Ford
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1998

8. AGE: Years	Months	Days	If less than one day
65 66	93	1	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Brick Manuf.

FATHER
12. Name John Ford
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Anna Smith
15. Birthplace Balto. Md.

16 (a) Informant Self
(b) Address

17 (a) Burial (b) Date thereof 3-22-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Baltimore - Md.
18 (a) Funeral director Mrs. Ida Bailey
(b) Address 1421 E. Jefferson St.
19 (a) MAR 20 1947 Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1947, at 3 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 11 1947 to March 16 1947 and that I last saw him alive on March 16 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage due to overexcert of rising Organ, Brain.	10 min.
Due to Arteriosclerotic Cardio-Vascular Disease	7 Yrs
Due to	
Other Conditions Benign Prostatic Hypertrophy & Vein. Retarie (Include pregnancy within 3 months of death)	1 Yr.

Date of operation 3-15-47
Major findings of operations B. P. H.
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William D. Gentry M. D.
Address Mercy Hosp. Date signed 3-16-47

VS 180

X

G49813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G49813 Registered No.

1. PLACE OF DEATH: 43 N. Culver St.
(a) Baltimore City, Maryland
(b) Street address 43 N. Culver St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 43 N. Culver St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sophie B. Stoll.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 4, 1861

8. AGE: Years 85 | Months 4 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business At Home.

FATHER
12. Name Adolph Stoll.
13. Birthplace Germany

MOTHER
14. Maiden Name Mary L. Hellermann
15. Birthplace Germany

16 (a) Informant Annie M. Stoll.
(b) Address 43 N. Culver St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md.

18 (a) Funeral director Dill Bros.
(b) Address 8109 Frederick Ave.

19 (a) (Date certificate received) MAR 20 1947 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19, 1947, at 2.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 17, 1947, to March 19, 1947, and that I last saw h[illegible] alive on Mar 18 1947.

Immediate cause of death	Duration
Cerebral Arteriosclerosis	1 month
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leonard Gaze MD

Address 3101 W. Baltimore St. Date signed 3/20 M. D. 47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

X

G49814

BALTIMORE CITY HEALTH DEPARTMENT 46E G49814
CERTIFICATE OF DEATH (FEDERLINE) Registered No.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 855 Washington Blvd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21-2
(e) Length of stay in Baltimore (yrs., mos., or days) 2yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 855 Washington Blvd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Cecilia Federline

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Peter Richard A

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19-1866

8. AGE: Years 80 | Months 8 | Days 0 | If less than one day hr. min.

9. Birthplace Ellicott City, Md (Town, county, and state)

10. Usual Occupation housework

11. Industry or business at home

FATHER 12. Name William Dunn
13. Birthplace Ellicott City, Md

MOTHER 14. Maiden Name Johanna A. Kelly
15. Birthplace Ireland

16 (a) Informant Mrs Viola Sullivan
(b) Address 855 Washington Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-24-47 (month) (day) (year)
(c) Cemetery or crematory St Marys Cem
Location Laurel, Md

18 (a) Funeral director John T Gorman & Son
(b) Address 901-03 Hollins St

19 (a) (Date rec'd by registrar) (b) Huntington Wilson Registrar, M

V S 150 MAR 20 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-19- 1947, at 3:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1947 to March 19 1947, and that I last saw h[illegible] alive on March 18 1947.

	Duration
Immediate cause of death Chronic Myocarditis	
Due to Coronary Occlusion	
Due to Pulmonary Tuberculosis	2 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Address 1901 Eutaw Pl Date signed 3/19/47

G49815
CME-109180

BALTIMORE CITY HEALTH DEPARTMENT.

CERTIFICATE OF DEATH

13B G49815

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Over 50 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 637 W. Pratt Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anton Zwingel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife Late Mary Zwingel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 26 1876

8. AGE: Years 70 | Months 4 | Days 26 | If less than one day hr. min.

9. Birthplace Lithuania (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name ? Sylvester Zwingel
13. Birthplace Lithuania

MOTHER
14. Maiden Name ? Milauskus
15. Birthplace Lithuania

16 (a) Informant Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/47 (Month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location 3800 Frederick Ave

18 (a) Funeral director Hurst Lorman & Son
(b) Address 501-03 Eutaw St.

19 (a) (Date rec'd by registrar) (b) Huntington Mills, Registrar

VS 150
MAR 20 1947

MEDICAL CERTIFICATION

P

20. DATE OF DEATH March 18 1947, at 6:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 15 1947 to March 18 1947, and that I last saw h... alive on March 18 1947.

Immediate cause of death Pulmonary Tuberculosis — Duration 4 mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. S. Shaler M. D.
Address Baltimore City Hosp. Date signed 18 March 47

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied.

BALTIMORE CITY HEALTH DEPARTMENT

G49816 — CERTIFICATE OF DEATH 937 — Registered No. G49816

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1840 W Baltimore St
(c) Hospital or institution: — 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1840 W. Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine A. Dowd

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: single
6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 2 1874

8. AGE: Years 72. Months 6 Days 16 If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business at home

FATHER
12. Name John F. Dowd
13. Birthplace England

MOTHER
14. Maiden Name Catherine O'Neill
15. Birthplace England

16 (a) Informant Mrs Mary E. Dowd
(b) Address 1840 W Baltimore Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/21/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Road

18 (a) Funeral director John J. Brown & Son
(b) Address 901 Hollins Street

19 (a) (Date rec'd by registrar) (b) Huntington Williams, Registrar, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/18/1947, at 5:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1947, to March 18 1947, and that I last saw him alive on 3/17/1947.

Immediate cause of death: Congestive Heart failure — Duration 2 wks.
Due to Arteriosclerosis Gen'l — 16 yr.
Due to Myocardial weakness & Valvular thickening.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Chas Norton Jr.
Address 1433 W Balto St Date signed 3/19/47 M.D.

VS 150 MAR 20 1947

correct age is especially important. Physicians: please write the

41-G19817 AND

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G19817

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write Rural and give town)
(d) Street No. 1364 Stockton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Nelson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary Nelson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-8-1888

8. AGE: Years 58 | Months 6 mo. | Days 11 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name George Nelson
13. Birthplace Maryland

MOTHER 14. Maiden Name Cora Roper
15. Birthplace Md

16 (a) Informant Records JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/24/47 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem't
Location Halethorpe Relta Md

18 (a) Funeral director Metropolitan Funeral Home
(b) Address 922 N. Mount St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-19- 1947, at 4:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 18 1947 March 19 1947.
and that I last saw h alive on March 19, 1947

	Duration
Immediate cause of death Generalized Peritonitis	36 hrs
Due to Puerperal sepsis Stillborn Fetus	36 hrs
Due to	
Other Conditions Carcinoma Lung and	?

(Include pregnancy within 3 months of death)
Date of operation 3/19/47
Major findings of operation: Same
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard C. Clay M. D.
Address Johns Hopkins Hosp. Date signed 3/19/47
for Dr. J. Lubinski, by H. J. Meadows, M. D.

VS 150

MAR 20 1947 Huntington Williams, M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C49818 ✓ Registered No. C49818

C49818 309

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1253 Battery Ave.
(c) Hospital or institution:
24-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1253 Battery Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mabel F. Parsons

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-10-4347

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/23/1897

8. AGE: Years	Months	Days	If less than one day
49	8	24	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Sewing Mach. Op.
11. Industry or business Safety Clothing Co.

FATHER
12. Name Leven Alford Parsons
13. Birthplace Md.

MOTHER
14. Maiden Name Araminta Billings
15. Birthplace Md.

16 (a) Informant Family
(b) Address 1253 Battery Ave.

17 (a) B (Burial, cremation, or removal) (b) Date thereof 3/21/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville
18 (a) Funeral director James L. McCarthy
(b) Address 130 E. Fort Ave.
19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. registrar

MAR 20 1947

vs 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 17 1947, at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 10 1947 to Mar 17 1947, and that I last saw h[illegible] alive on Mar 17, 47.

Immediate cause of death	Duration
Coronary Angiitis	10 minutes
Due to Atherosclerosis	2
Due to Lues	3
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter Kohn M.D.
Address 1026 Fort Ave. Date signed 3/19/47

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49819

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G49819

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution:
South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Morris Hill Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Morris Hill (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Smuck

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2, 1890

8. AGE: Years 56 | Months 8 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Self employed

11. Industry or business

FATHER
12. Name William Smuck
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Theresa Freesman
15. Birthplace Baltimore Md.

16 (a) Informant Harry Smuck
(b) Address Ritchie Highway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 22 47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Annapolis Blvd

18 (a) Funeral director John F Denny Inc
(b) Address 711 Light St.

19 (a) (b) Kensington Maryland

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/20/47 19 , at 5a. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 17 19 47 to March 20 19 47. and that I last saw h[illegible] alive on March 20 19 47.

Immediate cause of death 1° Burns of Face, Chest
Sepsis of Blood, Hands & Arms.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy:

Duration: 5 5 hrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident.
(b) Date of occurrence March 17, 1947 at 8 P. M
(c) Where did injury occur? Morris Hall (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? No
(e) Means of injury Kerosene Explosion

23. Signature Francis Hatland, Jr. M. D.
Address J. B. General Hosp Date signed March 20 19 47

Thomas J. Mercurio, M. D.

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49820

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G49820

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1226 Battery Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1226 Battery Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pearle Parr
3 (b) If veteran, name war
3 (c) Social Security Account No. 219-01-2679

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Louis Rose Parr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26 1861

8. AGE: Years 86 | Months - | Days 20 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation
11. Industry or business Produce Buyer

FATHER
12. Name Christian Parr
13. Birthplace Germany

MOTHER
14. Maiden Name Gertrude Rathgeber
15. Birthplace Germany

16 (a) Informant Gertrude Platt
(b) Address 1226 Battery Ave

17 (a) Burial (b) Date thereof 3-22-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location North Ave.

18 (a) Funeral director Wm. E. Milby Inc
(b) Address 2436 E. Oliver St

19 (a) (b)
(Date rec'd by registrar) Registrar

MAR 20 1947 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-18-47 19 at 6:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to 3-18-47 19, and that I last saw him alive on 3-18-47 19

Immediate cause of death	Duration
Pulmonary edema	
Due to Chronic myocarditis	4-5 yr
Due to Arterial arterio sclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature R. V. Rangle
Address 642 Wash. Blvd Date signed 3-19-47 M. D.

R. V. Rangle X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Thomas Morales
2900 Alameda Blvd. G49821

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G49821

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3305 Shannon Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3305 Shannon Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles W° Nelson, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Margaret I.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11, 1880

8. AGE: Years	Months	Days	If less than one day
66	11	7	hr. min.

9. Birthplace Balto. Maryland
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Charles W. Nelson
13. Birthplace ?

MOTHER
14. Maiden Name Pauline?
15. Birthplace ?

16 (a) Informant Mrs. Margaret Nelson
(b) Address 3305 Shannon Drive

17 (a) Burial (b) Date thereof 3/21/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

(a) Received by registrar (b) Huntington Williams M.D. Registrar
MAR 20 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 18th, 1947 at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 15 Mar 1947 to 18 Mar 1947 and that I last saw h[illegible] alive on 18 Mar 1947

Immediate cause of death Myocardial Insufficiency
Later Cerebral Hemorrhage — Duration 1 yr 4 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas L. Wardley Jr M.D.
Address 2900 Alameda Blvd. Date signed 19 Mar 47

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49822 | BALTIMORE CITY HEALTH DEPARTMENT | G49822 Registered No.

CERTIFICATE OF DEATH 122a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balt. Gen Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt.
(c) City or town Balt
(If outside city or town limits, write RURAL and give town)
(d) Street No. 95 Chapel St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa Batterdon
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced M
6 (b) Name of husband or wife Joseph
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov 16 1883
8. AGE: Years 61 Months 4 Days 3 If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Hsw
11. Industry or business

FATHER
12. Name George A. Schmidt
13. Birthplace Md.

MOTHER
14. Maiden Name Theresa Napf.
15. Birthplace Md.

16 (a) Informant Mrs. Oliver Drury
(b) Address 1549 Montpelier Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto
18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road
19 (a) (Date received by registrar) (b) Registrar

MAR 20 1947

VS-100

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1947 at 1:30 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 3-14 1947 to 3-19 1947 and that I last saw her alive on March 19 19 1947

Immediate cause of death	Duration
Bowel Obstruction	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 3-17-47
Major findings of operation: Bowel Obstruction
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Claude Sullivan M. D.
Address W. B. G. H. Date signed March 19 1947

X 1

G49823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G19823

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1157 Haubert St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1157 Haubert St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary F. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	W

6 (b) Name of husband or wife Richard T.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12. 1892

8. AGE: Years	Months	Days	If less than one day
54	5	6	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Martin Polzin
13. Birthplace Europe

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant Andrew L. Smith
(b) Address 1442 Hull St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-21-47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A.A. Co. Md

18 (a) Funeral director Flynn-Fleming
(b) Address 1426 Light St.

19 (a) [illegible] (b) [illegible] for William H. [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1947, at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 4 1946 to March 18 1947 and that I last saw h[illegible] alive on March 17 1947

Immediate cause of death	Duration
Acute Dilatation of Heart	1 day
Due to Hypertensive Cardio-Vascular Disease	Unk. 2 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Kenneth S. Mann M. D.
Address 516 Cathedral St Date signed 3-22-47

VS 150

X

G49824 ✓ G49824

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4000 Springdale Ave
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4000 Springdale Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Greenfeld

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Sarah
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14, 1884

8. AGE: Years	Months	Days	If less than one day
62	9	5	hr. min.

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation
11. Industry or business Real Estate

FATHER
12. Name Jacob Greenfeld
13. Birthplace Russia

MOTHER
14. Maiden Name Celia Mavis
15. Birthplace Russia

16 (a) Informant Mrs Sarah Greenfeld
(b) Address 4000 Springdale Ave

17 (a) Burial (b) Date thereof March 21, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh Cemetery
Location Windsor Mill Road

18 (a) Funeral director Sol Levinsen & Bros
(b) Address 1124-1126 W North Ave

19 (a) MAR 20 1947 (b) Augustus Williams, M.D.
(Date rec'd by registrar) (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1947 at 8.30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/17, 1947 to 3/19, 1947 and that I last saw h[illegible] alive on 3/19, 1947

Immediate cause of death: Arteriosclerotic Cardio-Vascular Disease — Duration P

Due to

Due to

Other Conditions Pulmonary Embolism — 30 min.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence 1947 at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. G. Grossman M. D.
Address 1109 N. Calvert St Date signed 3/20/47

VS 150

G49825 ✓ G49825

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1206 E. 33rd St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1206 E. 33rd St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Matilda Greenfeld ✓

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: late Alfred.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1854

8. AGE: Years 82 | Months | Days | If less than one day: hr. min. 865

9. Birthplace Vienna
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Joseph Sommers
13. Birthplace Vienna

MOTHER
14. Maiden Name Emma Wortman
15. Birthplace Vienna

16 (a) Informant Mr Martin Rood
(b) Address 1206 E 33rd St

17 (a) Burial (b) Date thereof Mar 21/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale
Location: Hamilton ave Rosedale

18 (a) Funeral director Sol Levinson & Bro.
(b) Address 1124-26 N. North ave

19 (a) 1947 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1947, at 6 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1944, to Mar. 20 1947, and that I last saw h. alive on March 20 1947.

Immediate cause of death: Cerebral arterio sclerosis - with infarctions of brain; Terminal hypostatic pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm Greenfeld

Address 1821 Eaton Pl. Date signed 3/20/47

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

Huntington Williams, M.D.

X

G49826

BALTIMORE CITY HEALTH DEPARTMENT ✓ G49826
CERTIFICATE OF DEATH 937 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address E. 33rd St
(c) Hospital or institution:
Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 208 E. Cold Spring Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clyde V. Matthews

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Sydney Wetherall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26 1879

8. AGE: Years	Months	Days	If less than one day
67	9	23	hr. min.

9. Birthplace Balto Co Md
(Town, county, and state)
10. Usual Occupation Dentist
11. Industry or business

FATHER 12. Name Dennis Marsh Matthews
13. Birthplace Balto Co Md

MOTHER 14. Maiden Name Harriet West Aldridge
15. Birthplace Charlestown W. Va.

16 (a) Informant J. Marsh Matthews
(b) Address Phoenix P.O. Balto Co Md

17 (a) Burial (b) Date thereof Mar 21 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore Md

18 (a) Funeral director Henry N. Jenkins Sons Co.
(b) Address McCulloh & Eutaw Sts.

19 MAR 20 19 (b) Huntington Williams M.D.
(Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1947, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1936 to Mar 19 1947 and that I last saw him alive on Mar 19 1947.

Immediate cause of death	Duration
Coronary Thrombosis	1 hr
Due to Arterio Sclerosis Myocardial	Gradual
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. N. Moody
Address 140 W Park Ave Date signed 3/20/47

correct age is especially important. Physicians; please write the causes of death clearly and legibly.

VS 150

G49827

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

Registered No. G49827

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd Sts
(c) Hospital or institution Union Mem. Hosp. 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 526 E. 20th St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ARTHUR LEROY DIETZ

3 (b) If veteran, name war —

3 (c) Social Security Account No. 23-03-2757

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife —

6 (c) If alive, give age —years

7. Birth date of deceased (mo., day, yr.) 8-25-76

8. AGE: Years	Months	Days	If less than one day
70	6	24	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Nurse

11. Industry or business —

FATHER 12. Name George W. Dietz

13. Birthplace Pennsylvania

MOTHER 14. Maiden Name Lucretia Reisinger

15. Birthplace Pennsylvania

16 (a) Informant Catherine J. Dietz

(b) Address 526 E 20th St Baltimore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/21/47 (month) (day) (year)

(c) Cemetery or crematory Lorraine

Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul St.

19 (a) (Date rec'd by registrar) (b) Harlan F. Hoffman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-19 1947 at 10:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-12 1947 to 3-19 1947 and that I last saw h[im] alive on 3/19 1947.

	Duration
Immediate cause of death Myocardial Insufficiency	2 hrs.
Due to Coronary Sclerosis	2 hrs.
Due to Prostatism	?
Other Conditions: Ca of prostate	?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify NYA or place)
(e) Means of injury

23. Signature [signature] M. D.

Address Union Mem. Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The ... information should be carefully supplied.

VS MAR 21 1947

Hop 9a 3-19-47

BALTIMORE CITY HEALTH DEPARTMENT

G49828 CERTIFICATE OF DEATH 467 Registered No. G49828

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3916 Parkheights Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3916 ParkHeights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Sandler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Benjamin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business House Work

FATHER
12. Name Morris Resnick
13. Birthplace Russia

MOTHER
14. Maiden Name Ida ?
15. Birthplace Russia

16 (a) Informant Meyer P Sandler
(b) Address 3916 ParkHeights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 21 (month) (day) (year)
(c) Cemetery or crematory Anshei Eminah Cong Cem
Location Hebrew Washington Road, Ce

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (Date received by Registrar) (b) Registrar

MAR 21 1947

VS 150

MEDICAL CERTIFICATION 3.20

20. DATE OF DEATH March 21 1947, at A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1946, to Mar 1947, and that I last saw h[illegible] alive on March 21 1947.

Immediate cause of death Coronary Occlusion — Duration 1 wk.

Due to Arteriosclerosis — ?

Due to

Other Conditions Cancer of the rectum

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Carcinoma of Rectum

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fredk. A. Coleman M.D.

Address 3700 Park Heights Ave Date signed March 21 1947 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The number of months should be carefully supplied.

G49829 Copy

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G49829

1. PLACE OF DEATH:
(a) Baltimore City, Maryland CATON AVE
(b) Street address BALTIMORE
(c) Hospital or institution:
ST AGNES HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTIMORE
(c) City or town CATONSVILLE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 17 INGLESIDE AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY F. MYERS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex MALE

5. Color or race WHITE

6 (a) Single, married, widowed, or divorced WIDOWED

6 (b) Name of husband or wife CAROLINE E. MYERS

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/16/1873

8. AGE: Years 73 Months 7 Days 3 If less than one day hr. min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual Occupation CUSTODIAN

11. Industry or business RETIRED

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant GEORGE H. MYERS
(b) Address 1 McCURLEY AVE - 28 -

17 (a) BURIAL (b) Date thereof 3-22-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory OLD SALEM
Location CATONSVILLE - MD

18 (a) Funeral director EDW. S. MACNABB
(b) Address CATONSVILLE - MD

19 (a) (b)
(Date rec'd by registrar)

MAR 21 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 19 1947, at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 6 1947, to Mar 19 1947 and that I last saw h[illegible] alive on Mar 19 1947

Immediate cause of death	Duration
Pneumonia	
Due to Hospitalization for Concussion	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Mar 6 - 1947 at 10 A.M.
(c) Where did injury occur? Home - Catonsville
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work?
(Specify type of place)
(e) Means of injury Fell down steps

23. Signature [illegible] M. D.
Address Hughes - Date signed

For Dr. W. B. Hufford by Howard S. Wilkinson, M.D.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 307

Registered No. G49830

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1422 Pennsylvania Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1422 Pennsylvania Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOANNA SMITH

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-15-1899

8. AGE: Years	Months	Days	If less than one day
47	7	4	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Edward Robinson
13. Birthplace Va.

MOTHER
14. Maiden Name Adline ?
15. Birthplace Va.

16 (a) Informant Mrs. U.B. Douglas
(b) Address 1338- Divisision Street.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 22 47 (month) (day) (year)
(c) Cemetery or crematory Cebutus Mem Park
Location Baltimore County Md

18 (a) Funeral director William Jackson
(b) Address 916 Penna ave

19 (a) MAR 21 1947 (b)
(Date received by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19, 1947, at 5.30 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Syphilitic aortitis, with aneurysm of aorta.
Due to Pulmonary edema.

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D.
Medical Examiner.
Date signed 3-20-47

Huntington Williams, M.D.

D49831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G49831
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Upperco.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rosie B. Tracey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Silas E Tracey

6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) March 14-1883

8. AGE: Years 64 | Months - | Days 7 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER 12. Name Joseph Wentzville
13. Birthplace Md

MOTHER 14. Maiden Name Amanda Boring
15. Birthplace Md

16 (a) Informant Silas E Tracey
(b) Address Upperco Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-23-47 (month) (day) (year)
(c) Cemetery or crematory Mt Zion
Location Balto Co. Md.

18 (a) Funeral director Edw A Tipton
(b) Address Hampstead Md

19 (a) ____ (Date rec'd by registrar) (b) ____ Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1947, at 12 10 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 20 1947 to Mar 21 1947, and that I last saw h[illegible] alive on Mar 21 1947.

Immediate cause of death	Duration
Cardiac failure	
Due to Coronary Thrombosis	
Due to Hypertensive arteriosclerotic Cardiovascular disease.	
Other Conditions Generalized arteriosclerosis Obesity, marked.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J Tracey M. D.
Address University Hosp. Date signed 3-21-47

VS 150 MAR 21 1947 Huntington Williams, M.D.

X

please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G49832 — Registered No. 133 G49832

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: MONUMENT ST
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: MD (b) County:
(c) City or town: Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 2521 Shirley Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: Hyman Katzoff

3 (b) If veteran, name war: —
3 (c) Social Security Account No.: —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife: ANNA
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1876

8. AGE: Years	Months	Days	If less than one day: hr.	min.
71				

9. Birthplace: Russia (Town, county, and state)
10. Usual Occupation: RETIRED
11. Industry or business:

FATHER
12. Name: Max
13. Birthplace: Russia

MOTHER
14. Maiden Name: Goldie
15. Birthplace: Russia

16 (a) Informant: Hospt. Records
(b) Address:

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-21-47 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Young Men
Location: Windsor Mill Rd
18 (a) Funeral director: Jack Lewis Inc
(b) Address: 2108 Gutaw Pl.
19 (a) (Date rec'd by registrar) (b) Registrar

VS MAR 21 1947 Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 March 1947, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/25 1946, to 3/20 1947, and that I last saw h~~im~~ alive on 3/20 1947

Immediate cause of death	Duration
pulmonary edema & cardiac decompensation	
Due to myocardial failure	
Due to Cachexia, debility & chronic pyelonephritis	
Other Conditions Parkinsonism, arteriosclerosis, Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Harold L. Gordon M. D.
Address: Sinai Hosp. Date signed 3/20/47

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information must be correctly supplied.

G49833

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. G49833

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4507 Arabia Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2726 Hugo Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CATHERINE E. ANDERSON

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Elwood L. Anderson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 17, 1872

8. AGE: Years	Months	Days	If less than one day
61 (74)	6	2	hr. min.

9. Birthplace Philadelphia, Pa.
(Town, county, and state)
10. Usual Occupation -
11. Industry or business

FATHER
12. Name Abraham Collier
13. Birthplace Ireland

MOTHER
14. Maiden Name Emma E. Gulden
15. Birthplace Osford, Pa.

16 (a) Informant Mr. Elwood L. Anderson
(b) Address 2726 Hugo Ave.

17 (a) Burial (b) Date thereof 3/22/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS MAR 21 1947 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19, 1947, at 6:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946 to March 19 1947
and that I last saw ... alive on March 19 1947.

Immediate cause of death:	Duration
Acute Circulatory Collapse	3 hours
Due to Generalized Carcinoma - Metastatic	
Due to Carcinoma of Left Ovary.	8 mos.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation July 1946
Major findings of operation: Carcinoma of Left Ovary
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide -
(b) Date of occurrence - at M
(c) Where did injury occur? - - -
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? - While at work?
(Specify type of place)
(e) Means of injury -
23. Signature James E. White M.D.
Address 524 Harford Rd. Date signed March 20 1947

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49834

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √94a

Registered No. G49834

Type or print plainly in ink. Give the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2908 Shirey Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2908 Shirey Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME George William Pfeffer

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Annie Pfeffer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept. 8, 1866

8. AGE: Years 80 | Months 6 | Days 11 | If less than one day ____ hr. ____ min.

9. Birthplace: Balto., Md.
(Town, county, and state)

10. Usual Occupation: Real Estate

11. Industry or business

FATHER
12. Name: Frederick Pfeffer
13. Birthplace: Germany

MOTHER
14. Maiden Name: Katherine Dannenfelser
15. Birthplace: Germany

16 (a) Informant: Miss Katherine Pfeffer
(b) Address: 2908 Shirey Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/47 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cem.
Location: Baltimore, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) ____ (Date rec'd by registrar) (b) ____ Registrar

MAR 21 1947 Huntington W. [illegible] M.D.

VS-191

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19, 1947, at 9.15 a M

21. I certify that I took charge of the remains described above, held an insp. & inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 3-19-47

X

G49835

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G49835

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 217 E. 21st St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 217 E. 31st St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JESSE A. BANDY

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	216-03-9029

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Minnie Bandy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 28, 1882

8. AGE: Years	Months	Days	If less than one day
64	11	21	hr. min.

9. Birthplace Missouri
(Town, county, and state)
10. Usual Occupation Handy Man
11. Industry or business Country Club of Md.

FATHER
12. Name Unknown
13. Birthplace -

MOTHER
14. Maiden Name Unknown
15. Birthplace -

16 (a) Informant Mrs. Minnie Bandy
(b) Address 217 E. 21st St.
17 (a) Burial (b) Date thereof 3/21/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.
19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 19, 1947, at 1:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1945 to 3/19 1947 and that I last saw him alive on 3/19 1947

	Duration
Immediate cause of death Coronary occlusion	5 hrs.
Due to Arteriosclerosis	15 yrs.
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy: Coronary occlusion. Sch.	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury
23. Signature Victor Tickner M. D.
Address 321 DUNKIRK. Date signed 3/19/47

VS 150

Huntington Williams, M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49836

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Reg. G49836

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Garrison Blvd.
(c) Hospital or institution: Garrison Nursing Home 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 Linden Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AGNES C. KEENAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Separated

6 (b) Name of husband or wife Walter S. Keenan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15, 1885

8. AGE: Years	Months	Days	If less than one day
62	0	4	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name Philip W. Hess
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary H. Rooney
15. Birthplace Ireland

16 (a) Informant Mrs. Genevieve H. Webb
(b) Address 1400 Linden Ave.

17 (a) Burial (b) Date thereof 3/22/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19, 1947, at 7:45p M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1945 to March 19 1947 and that I last saw her alive on March 18 1947.

Immediate cause of death	Duration
Cardio-Respiratory Failure	
Due to Carcinoma Colon,	
Due to Possible Cerebral Metastasis	
Other Conditions Spastic Paralysis Following Cervical Disc Operation	

(Include pregnancy within 3 months of death)
Date of operation Dec 1945
Major findings of operation: Cervical disc (ruptured) with cord edema
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Meuland Edward Day M. D.
Address 4-E-33rd St Balto 18 Date signed March 21 47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

Huntington Williams M.D.

X

G49837

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163 M

G49837 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
Union Memorial Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4005 Keswick Road.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Leslie Allen Wingo

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Kathryn Balton Wingo
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 1, 1895

8. AGE: Years	Months	Days	If less than one day
51	8	18	.....hr. .....min.

9. Birthplace Petersburg, Va.
(Town, county, and state)
10. Usual Occupation.....
11. Industry or business

FATHER
12. Name Charles. S. Wingo
13. Birthplace Amelia Co., Va.

MOTHER
14. Maiden Name Mamie Johnson
15. Birthplace Petersburg, Va.

16 (a) Informant Mrs. Kathryn B. Wingo
(b) Address 4005 Keswick Rd.

17 (a) Removal (b) Date thereof 3/22/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory *
Location Petersburg, Va.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 21 1947 (b) .....
(Date received by Registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19. 1947, at 12.30 P. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation
Due to Automobile exhaust fumes
Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-19-47 at 12 p. M.
(b) Where did injury occur? 4005 Keswick Road.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No
(d) Means of injury Inhalation auto exhaust fumes.
23. Signature Howard J. Adkins M.D.
Medical Examiner.
Date signed 3-19-47

X

S 19838 5/17262

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

Registered No. 19838

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 7-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 706 N. Madeira St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry Lohman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Estelle Lohman

6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) 11-5-75

8. AGE: Years 68 | Months 4 | Days 15 | If less than one day hr. min. 18

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business -

FATHER
12. Name Henry Lohman
13. Birthplace Md

MOTHER
14. Maiden Name Kate Albrecht
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-22-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Balt Md

18 (a) Funeral director Frank Burkhardt
(b) Address 900 N. Eutaw St

19 (a) MAR 21 1947 (Date received by registrar) (b) Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 20 1947 at 9 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 14 1947 to Mar 20 1947 and that I last saw him alive on Mar. 20 1947

Immediate cause of death	Duration
9-3 Hemorrhage	
Due to 9-3 Lesion (Neoplasm) ?	
Due to	
Other Conditions Uremia, BPH	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert S. Donohue M. D.
Address J H H Date signed 3-20-47

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49839

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93c

G49839 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2207 Etting St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2207 Etting St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Scott White

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Josephine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 29 1873

8. AGE: Years 73 | Months 11 | Days 27 | If less than one day hr. min.

9. Birthplace St. Michaels, Md. (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name George White
13. Birthplace St. Michaels, Md

MOTHER
14. Maiden Name Anderson
15. Birthplace

16 (a) Informant: James L. White
(b) Address 2207 Etting St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/21/1947 (Month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
(d) Location Baltimore Md

18 (a) Funeral director Geo. H. Hubbard
(b) Address 763 Druid Hill Ave

19 (a) (Date received) MAR 21 1947 (Address) Huntington Ave.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/16/ 1947, at 7 00 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-11-1947 to 3-16-1947 and that I last saw him alive on 3-11-1947

Immediate cause of death: Myocarditis — Duration

Due to:

Due to:

Other Conditions: Arthritis

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature McDonald Bando M. D.

Address 2445 Druid Hill Ave Date signed 3-21-47

X

BALTIMORE CITY HEALTH DEPARTMENT

G49840 BC# F80510 CERTIFICATE OF DEATH 33a

Registered No. G49840

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 827 W Cross St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 827 W Cross St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Edith Day

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17, 1943

8. AGE: Years 3 | Months 8 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Charles W. Day
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Agnes M Colahan
15. Birthplace Baltimore, Md

16 (a) Informant Mr Charles W. Day
(b) Address 827 W. Cross St

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 3/22/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location W 30 & Old Fed Road

18 (a) Funeral director John Bowers & Son
(b) Address 901-23 Fallsway St.

19 (a) (Date rec'd by registrar) (b) Hunting for Williams Registrar

VS 150 MAR 21 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/20/1947 at 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-17-1947 to 3-20-1947 and that I last saw her alive on 3-20-1947

Immediate cause of death Pneumonia
Influenza Bronchitis
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration one day

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis J. Klapp MD M. D.
Address 96 Wolfe St Date signed

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

X 3/20/47

G49841

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered G49841

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinia
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5815 Belair Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter T Weaver

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 9, 1877

8. AGE: Years	Months	Days	If less than one day
69	7	10	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Con. Can Co.

FATHER
12. Name John
13. Birthplace Baltimore

MOTHER
14. Maiden Name Caroline Pugh
15. Birthplace South Carolina

16 (a) Informant Mrs. Mamie Bell
(b) Address 5815 Belair Rd

17 (a) Burial (b) Date thereof 3/22/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave & Rose St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) (b)
(Date rec'd by registrar) Registrar

MAR 21 1947 Huntington Hill

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/17 1947, at 1:54 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/17 1947, to 3/19 1947, and that I last saw h[illegible] alive on 3/17 1947.

Immediate cause of death	Duration
Cardiac failure & coronal thrombosis & pneumonia.	
Due to Accd. C.V. accident	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address [illegible] Date signed 3/19 1947
M. D.

Birth Certificate
G49842 / D.23785

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH / 153

Registered No. G49842

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Laynes Ave 16
(c) Hospital or institution: West Balto Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 7

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2906 W. Lafayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Vacek

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: S
6 (b) Name of husband or wife: none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12 1947

8. AGE: Years | Months | Days: 7 | If less than one day: hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation infant
11. Industry or business none

FATHER
12. Name Francis Vacek
13. Birthplace Baltimore

MOTHER
14. Maiden Name Ruth Miller
15. Birthplace Baltimore

16 (a) Informant
(b) Address 2906 Lafayette Ave 16

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-21-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4300 Belair Rd

18 (a) Funeral director Harry H. Wetzler
(b) Address 4101 E. Lombard St

19 (a) [illegible] (Date received by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-20- 1947, at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-12 1947 to 3-20 1947, and that I last saw him alive on 3-20 1947.

Immediate cause of death	Duration
Unknown	
Due to	
Due to	
Other Conditions: Scleroderma, Cyanosis, edema	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Not Obtained

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. D. Trepteau M. D.
Address W. Balto Gen Hosp Date signed 3-20-47

VS 150

G49843

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G49843 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3414 Dolfield Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3414 Dolfield Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Isaac Schofer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Lena

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 15 1874

8. AGE: Years 72 | Months 5 | Days 6 | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name unknown
13. Birthplace Russia

MOTHER 14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Herman Schofer
(b) Address 3417 Dolfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-21-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phila Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1422 E Balto St

19 MAR 21 1947 (b) Registered by Registrar Williamsport Md
Huntingtown

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-21-1947, at 4:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 19 to 3/21 1947 and that I last saw him alive on 3/20 1947.

Immediate cause of death	Duration
(a) Cerebral hemorrhage	2
Due to (b) Coronary sclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Oneeta B Lewis
Address 7904 Pratt Rd Date signed 3/24/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

C43844
CWR-105991

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓ 93D

C43844
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 631 W. Lee Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Harrison

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-07-6049

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. ?, 1887

8. AGE: Years ? 60 | Months ? 1 | Days ? 17 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Eddie Harrison
13. Birthplace South Carolina

MOTHER
14. Maiden Name Hattie ?
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 23, 1947 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn Cemtery
Location Baltimore City

18 (a) Funeral director Joseph A. Sisely
(b) Address 66 West Pratt Street

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1947, at 9:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 8 1947, to March 19 47 and that I last saw h... alive on March 19 1947.

Immediate cause of death	Duration
Pulmonary infarction	
Due to	
Due to	
Other Conditions Bronchopneumonia, Hypostatic congestion	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy ... about

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. Rowell Williams M. D.
Address Baltimore City Hosp. Date signed 20 Mar 47

Washington Williams, M.D.

VS MAR 21 1947

1111a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49845

CHK-107996

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

R G49845

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 73
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 2- 4-
(e) Length of stay in Baltimore (yrs., mos., or days) 67- 2- 4-

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 131 N. West Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
David Washington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 15-1880

8. AGE: Years 67 | Months 2 | Days 4 | If less than one day ... hr. ... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Cornelius Washington
13. Birthplace ?

MOTHER
14. Maiden Name Emma Warren
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 21, 1947 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn Cemetery
Location Baltimore City

18 (a) Funeral director Joseph A. Sisly
(b) Address 66 West Baltimore Street

19 (a) March 21 1947 (b) ... (Signature of registrar) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH March 19 19 47, at 3:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 28 19 47, to Mch. 19 19 47, and that I last saw him alive on Mch. 19 19 47.

Immediate cause of death: Myocardial Infarction — Duration: Days

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. Rowell Hoffman M. D.

Address Baltimore City Hospitals Date signed 20 Mar. 47

correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G49846

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1314

Registered No. G49846

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5206 Cuthbert Ave.,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5206 Cuthbert Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie C. Norwood,

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife A. J. Norwood,
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1892

8. AGE: Years	Months	Days	If less than one day
54	4	7	hr. min.

9. Birthplace Campus, Ill.
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business at home

FATHER
12. Name David Murphy,
13. Birthplace Ireland,

MOTHER
14. Maiden Name Marie Kelly,
15. Birthplace Ill.

16 (a) Informant Mr. A. J. Norwood,
(b) Address 5206 Cuthbert Ave.

17 (a) Burial (b) Date thereof 3/22/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral,
Location Baltimore City,

18 (a) Funeral director Le. Vernon Lemmon,
(b) Address 4611 Park Heights Ave.

19 (a) MAR 21 1947 (b) Registrar Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18, 1947, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1946, to 3/18 1947, and that I last saw her alive on 3/18 1947

Immediate cause of death: Lobar Pneumonia

Due to: Hypostatic

Due to: Chronic Interstitial Nephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles J. Kelly

Address 5276 Park Heights. Date signed Mar 20 1947 D.

V S 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49847

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G49847 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 206 S. Maderia
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 206 S. Maderia St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter J. Zegorek

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-14-2809

4. Sex M.

5. Color or race W

6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Catherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years 52 | Months | Days | If less than one day hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Oilcloth.

11. Industry or business Baker Whitley

FATHER
12. Name Frank Zegorek
13. Birthplace Poland

MOTHER
14. Maiden Name Frances Komosa KOMOSA
15. Birthplace Poland.

16 (a) Informant Catherine Zegorek
(b) Address 206 S. Maderia St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location Balto, Co.

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern Ave

19 (a) Dated 1947 (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-19 1947, at 8-15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-9 1947, to 3-18 1947, and that I last saw h/[illegible] alive on 3-18 1947.

Immediate cause of death: Hypertensive Cardio-vascular disease — Duration 2 yrs
Due to: Cardiac Hypertrophy — Dilatation of aorta — Duration 4 " "
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify kind of place)
(e) Means of injury

23. Signature [signature] F. Chiappa
Address 5217 York Rd Date signed 3/19/47

Correct age is especially important. Physicians; please write the causes of death clearly and legibly.

MD21 Huntington Williams, M.D.

C49848 5-11681

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

Registered No. C49848

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State N. C. (b) County
(c) City or town Reidsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 137 Racine Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Judith Irene Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced. ✓

6 (b) Name of husband or wife ✓

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 20, 1942

8. AGE: Years 5 | Months 2 | Days 0 | If less than one day hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Claude Wilbur Smith

13. Birthplace North Carolina

MOTHER 14. Maiden Name Dorothy McDaniel

15. Birthplace Virginia

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Interment (Burial, cremation, or removal) (b) Date thereof 3-22-47 (month) (day) (year)

(c) Cemetery or crematory Reidsville Cem.

Location Reidsville N. C.

18 (a) Funeral director Leonard D. Rauch

(b) Address 5305 Harford Rd

19 (a) (Date received by Registrar) MAR 21 1947 (b) Registrar Huntington Williams, M.D.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1947, at 2:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 18 1947, to March 20 1947, and that I last saw her alive March 20 1947

	Duration
Immediate cause of death: Congenital heart disease	Life
Due to	
Due to	
Other conditions: Tetralogy of Fallot (Include pregnancy within 3 months of death)	
Date of operation 3/19/47	
Major findings of operation: Pulmonary stenosis	
of autopsy: Same	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry L. Bahnson M.D.

Address Johns Hopkins Hosp. Date signed 3/20/47

Please write the cause of death clearly and legibly. Physicians: please correct age is especially important. The

G49849 | BALTIMORE CITY HEALTH DEPARTMENT | G49849

CERTIFICATE OF DEATH 131 B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun
(c) Hospital or institution:
Franklin Square Hosp. ?
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Maryland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3105 Weaver Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Edris S. Willis (Edris S. Willis)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Catherine Willis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-22-77

8. AGE: Years	Months	Days	If less than one day
69	6	28	hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation Retired Railroad man
11. Industry or business

FATHER
12. Name Edris Willis
13. Birthplace Va.

MOTHER
14. Maiden Name Annie Ragland
15. Birthplace Va.

16 (a) Informant Catherine Willis, Wife
(b) Address 3105 Weaver Ave.

17 (a) Burial (b) Date thereof Mch 23/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Taylor ave Hamilton

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1960 Eutaw Place

19 (a) 3/21/47 (b)
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 20 1947, at 4:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 19 1947, to Mar 20 1947, and that I last saw h.im alive on Mar 20 1947

Immediate cause of death Uremia

Duration 24 hrs.

Due to Chronic glomerulo-nephritis

Duration yrs.

Due to

Other Conditions Obstruction of common bile duct

Duration 6 days.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature My Myerson Straus M. D.
Address 20. Date signed 3/19/47

VS 150

correct age is especially important. Physicians; please write the ... information should be carefully supplied. The ... the causes of death clearly and legibly.

G49850
510324

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓469

G49850
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A. A. County.
(c) City or town Annapolis
(If outside city or town limits, write RURAL and give town)
(d) Street No. 850 West St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Naomi Ruth Butts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Sep. Married

6 (b) Name of husband or wife Roy E. Butts
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-20-1900

8. AGE: Years	Months	Days	If less than one day
46	8	1	hr. min.

9. Birthplace W. Va.
(Town, county, and state)
10. Usual Occupation Seamstress
11. Industry or business

FATHER
12. Name Charles Middleton
13. Birthplace W. Va.

MOTHER
14. Maiden Name Daisy Wichmeyer
15. Birthplace W. Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 3/24/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Bluff
Location Annapolis Md.

18 (a) Funeral director E. Miller Lamerson
(b) Address 1003 W Baltimore St.

19 (a) (b)
(Date rec'd by Local Registrar) (Signature of Local Registrar)

MAR 1 1947

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

A

20. DATE OF DEATH March 21 1947, at 3.05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 19 1947 to March 21 1947 and that I last saw him alive on March 21 1947.

Immediate cause of death	Duration
Carcinoma of pancreas with multiple metastases to lymph	
Due to nodes and bones	3 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert C. Austrian, M. D.
Address John Hopkins Hosp. Date signed 3/24/47

X

G49851 BCH# 18911

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓14

Registered No. G49851

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 2 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1529 E. Fayette St. (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME LeRay Carmichael

3 (b) If veteran, name war..... (c) Social Security Account No.

4. Sex Male | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced. ✓

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 16, 1945

8. AGE: Years 2 | Months 2 | Days 3 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation.....

11. Industry or business.....

FATHER 12. Name LeRay Carmichael deceased
13. Birthplace S. Carolina

MOTHER 14. Maiden Name Louise Stinson
15. Birthplace S. Carolina

16 (a) Informant Record
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location.....

18 (a) Funeral director Elroy A Wilson
(b) Address 1000 Biddle St Ave

19 (a)..... (Date rec'd by registrar) (b)..... Registrar

MAR 21 1947 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1947, at 10:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 18 1947, March 19 1947, and that I last saw h[illegible] alive March 19 1947.

	Duration
Immediate cause of death: Tuberculous meningitis	2 weeks
Due to —	
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation..... Major procedures.....

Major findings of operations:.....

of autopsy:.....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature Leonard Rosenman M. D.
Address Johns Hopkins Hospital Date signed 3/24/47

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49852

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 486 G49852

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1044 N. Eden St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1044 N. Eden St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Tubman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Col

6 (a) Single, married, widowed, or divorced: Sep.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1884

8. AGE: Years 62 | Months 5 | Days 18 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name John C. Thompson

13. Birthplace md.

MOTHER 14. Maiden Name Emmaline Slater

15. Birthplace md.

16 (a) Informant Gladys Washington

(b) Address 1010 N Bond St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/23/47 (month) (day) (year)

(c) Cemetery or crematory Ft Calvary

Location Elroy Aldridge Son

18 (a) Funeral director

(b) Address 1000 Brantly ave

19 (a) Date rec'd by registrar (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20th 1947, at 7:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 5 1946 to March 20 1947, and that I last saw h[illegible] alive on Mar. 20 1947.

Immediate cause of death: Cerebral Hemorrhage

Due to: Pneumonia

Due to:

Other Conditions: Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Neal A. Lafourcade

Address 822 N. Bond Date signed 3/24/47

Registrar

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49853

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93a

G49853 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 521 S. Caroline
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 521 S. Caroline St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gaddie Weasley Brown

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: W.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 3, 1891

8. AGE: Years 55 | Months 4 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name James Watkins
13. Birthplace unknown

MOTHER 14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Ida Hall
(b) Address 521 S. Caroline St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Thos O. Wilson
(b) Address 1000 Eastlyane

19 (a) MAR 21 1947 (Date rec'd by registrar) (b) Registrar

Huntington Hillsdale, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-19 1947, at 6 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-18 1947 to 3-19 1947 and that I last saw h[illegible] alive on 3-19 1947.

Immediate cause of death: Acute Myocarditis — Duration: 1 day
Due to: Cerebral Apoplexy — 2 days
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. H. Long Long M. D.
Address 1420 E. Chase Date signed 3-21-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

Howell

G49851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54a

G49854 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green & Lombard.
(c) Hospital or institution: Univ. Hosp. 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 16 East west St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Howell

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, (widowed) or divorced.

6 (b) Name of husband or wife ROBERT L. HOWELL Not Living

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 21, 1924

8. AGE: Years 23 | Months 1 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation H.W.

11. Industry or business

FATHER 12. Name Robert Carey

13. Birthplace Balto.

MOTHER 14. Maiden Name Minnie [illegible] Beard

15. Birthplace Balt.

16 (a) Informant Mother

(b) Address Same

17 (a) Burial (b) Date thereof 3-24-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore National
Location Frederick Road.

18 (a) Funeral director Joseph T. Cochran, Jr.

(b) Address 414 N. Franklintown Rd.

19 (a) (b)
(Date rec'd by registrar) Registrar

VS 150 MAR 21 1947 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-20 1947, at 3:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-4 1947 to 3-20 1947 and that I last saw h.er alive on 3-20 1947.

	Duration
Immediate cause of death Glioblastoma of brain with	
Due to Increased intracranial pressure & destruction of	
Due to vital centers	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Weissman M. D.

Address Univ. Hosp. Date signed 3-20-47

X X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49855

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 478

Registered G49855

1. PLACE OF DEATH:
(a) Baltimore City, Maryland St Agnes Hospital
(b) Street address (3903 Southern)
(c) Hospital or institution:
Eaton & Wilkens Ave.
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town..... (If outside city or town limits, write RURAL and give town)
(d) Street No. 3903 Southern Ave. (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Ryda Wolkenfuss

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Herman L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 27 - 1884

8. AGE: Years	Months	Days	If less than one day
62	2	21 24	hr. min.

9. Birthplace..... (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Hilary Hudson
13. Birthplace Md.

MOTHER
14. Maiden Name Carrie Baker
15. Birthplace Md.

16 (a) Informant Herman C. Wolkenfuss
(b) Address 3903 Southern Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-24-47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave
18 (a) Funeral director John E. Miller Jr
(b) Address 24 3/5 E. Mulberry St
19 (a)..... (b)..... (Date rec'd by registrar) Registrar

MAR 21 1947 Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 March 1947, at 2 42 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 10 1947, to Mar 20 1947, and that I last saw h.er alive on 20 Mar 1947

Immediate cause of death	Duration
Respiratory failure	
Due to Metastatic carcinoma of lungs, mediastinum + axillary	
Due to lymph glands	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....
23. Signature John C Oppenheimer M.D. M. D.
Address St Agnes Hosp. Date signed Mar 20, 1947

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G49856

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1216 Whitelock Ave
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Ben Oliver

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1903

8. AGE: Years	Months	Days	If less than one day
44			....hr. ....min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Labourer
11. Industry or business —

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Cora Grimes
(b) Address 602 Pitcher St

17 (a) Burial (b) Date thereof 3-21-47
(burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo E. Kelson
(b) Address 1303 Christman St

19 (a) MAR 21 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/11 1947, at 1:30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial Degeneration

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature P. L. Sulzbacher M.D.
Medical Examiner.
Date signed 3/12/47

49857

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓167

G49857
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 11 N. Exeter Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Robt. Sinclair Bowen (Bowens)

3 (b) If veteran, name war

3 (c) Social Security Account No. 702-03-201[illegible]

4. Sex: M | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Maudeline Bowens

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5, 1914

8. AGE: Years 33 | Months - | Days 15 | If less than one day hr. min.

9. Birthplace Savannah, Ga. (Town, county, and state)

10. Usual Occupation Merchant Marine

11. Industry or business

FATHER
12. Name Robert Bowen
13. Birthplace South Carolina

MOTHER
14. Maiden Name Anna Neet
15. Birthplace South Carolina

16 (a) Informant Anna Bowens (Mother)
(b) Address 11 N. Exeter Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/24/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Robert L. Gorsuch

18 (a) Funeral director
(b) Address 1216 E. Carrollton Ave.

19 (a) MAR 21 1947 (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION 35

20. DATE OF DEATH March 20, 1947, at 1 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab wound of chest involving mammary artery

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/20/47 at 12:30 A. M.
(b) Where did injury occur? In front of 127 Augusta Street
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Stabbing - Sharp Instrument

23. Signature Howard J. Cunningham M.D.
Medical Examiner.
Date signed 3/20/47

VS 151

X

G49858

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √52B

Registered No. G49858

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 521 Overdale Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) Y
(e) Length of stay in Baltimore (yrs., mos., or days) 90yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 521 Overdale Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herman Knollenberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	widowed

6 (b) Name of husband or wife Late Louisa H. Knollenberg
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 30, 1855

8. AGE: Years	Months	Days	If less than one day
91	10	19	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Knollenberg
13. Birthplace Germany

MOTHER
14. Maiden Name Schaffer
15. Birthplace Germany

16 (a) Informant Charles H. Behm
(b) Address 521 Overdale Rd.

17 (a) Cremation (b) Date thereof 3/22/47.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location 3801 Frederick Rd

18 (a) Funeral director Harry H. Knight
(b) Address 4101 Edmondson Ave

19 MAR 21 1947 (b) Interred in Woodlawn
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/19/47. 19..., at 2P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/17 1947 to 3/19 1947, and that I last saw h[illegible] alive on 3/19 1947

Immediate cause of death	Duration
Hemorrhage from Neoplasm Bladder	5 da.
Due to Ca of Bladder	1yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wilson K. Gallagher M. D.
Address Catonsville 28, Md. Date signed 3-21-47

V S 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49859

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117B

G49859 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Aves
(c) Hospital or institution:
St. Agnes Hosp. 2nd
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - 23
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3036 Strickland
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank E. Schwallenberg

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-01-4033

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21, 1892

8. AGE: Years	Months	Days	If less than one day
54	10	29	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Brushman

11. Industry or business

FATHER
12. Name George Schwallenberg
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Curran
15. Birthplace Md

16 (a) Informant Mrs. Martin Schwallenberg
(b) Address 3036 Strickland St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 22 1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd

18 (a) Funeral director Harry A Glatzer
(b) Address 4101 Edmondson Ave

19 (a) MAR 21 1947 (Date rec'd by registrar) (b) Huntington Nolling[illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/20 1947, at 9:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/13 1947 to 3/20 1947 and that I last saw him alive on 3/26 1947.

Immediate cause of death Coronary Occlusion. Sudden death

Due to

Due to

Other Conditions Bleeding duodenal ulcer

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. Clarence Cohn M.D.
Address 2201 N. Charles St. Date signed 3/20/47

Cohn

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G15860

9860 5 11 0924 5632 8 1046

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Fairfield (If outside city or town limits, write RURAL and give town)
(d) Street No. 1417 Grinder St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hilda Keith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Black

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-11-46

8. AGE: Years | Months 6 | Days 9 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Keith
13. Birthplace Ga

MOTHER 14. Maiden Name Lillie Crawford
15. Birthplace Ga

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch. 23/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director James A Sayes
(b) Address 142 W Lee St

19 (a) MADDOX & (b) Hunting Town, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 20 1947 at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 18 1947 to Mar 20 1947 and that I last saw h[illegible] alive on Mar 20 1947.

Immediate cause of death	Duration
Lobar Pneumonia or Bronchopneumonia	
Sinus Thrombosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Luther Leonhard M. D.
Address Johns Hopkins Hosp. Date signed 3-21-47

VS 150

C49861

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 3/13B

Registered No. C49861

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 787 ~~Ad~~ George St
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Dolores RIVERS

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-8-32

8. AGE: Years	Months	Days	If less than one day
14	9	12	.....hr. .....min.

9. Birthplace Md
(Town, county, and state)
10. Usual Occupation.....
11. Industry or business.....

FATHER
12. Name John Rivers
13. Birthplace S. C.

MOTHER
14. Maiden Name Elvira Williams
15. Birthplace S. C.

16 (a) Informant John Williams
(b) Address 787 George St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 23 47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director Wm A Jackson
(b) Address 916 Pennsa ave

19 MAR 22 1947 (Date rec'd by registrar) Huntington Williams (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1947, at 7 a. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Tuberculosis of lungs, with tuberculous pneumonia and miliary tuberculosis.
Due to
Tumor of brain (meningioma)
Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature George A. Mesnil M.D.
Medical Examiner.
Date signed 3/21/47

VS 181

G49862

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G49862 Registered No. 8012

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Belair
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Adams

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) (Single) married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) [illegible] 10 [illegible] 5/1937

8. AGE: Years 9 | Months 10 | Days | If less than one day hr. min.

9. Birthplace Belair, Md., July 29, 1937 (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Thomas L. Adams
13. Birthplace Md.

MOTHER
14. Maiden Name Marcelene Kefauver
15. Birthplace Md.

16 (a) Informant Thomas L. Adams,
(b) Address R.D. 2, Belair, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-23-47 (month) (day) (year)
(c) Cemetery or crematory Churchville
Location Presb. Cem. Churchville, Md.

18 (a) Funeral director Dean & Foster
(b) Address Belair Md

19 (a) [illegible] (b) Huntington Williams M.D.

MAR 22 1947
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/20 1947, at 5:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/19 1947, to 3/20 1947, and that I last saw her alive on 3/20 1947

Immediate cause of death	Duration
Pulmonary edema	
Due to Medullary failure	
Due to Encephalitis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. M. N. Crosby
Address Univ. Hosp. Date signed 3/20

X

G49863 Birth Certificate G-19820

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

Registered No. G49863

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1324 Druid Hill Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1324 Druid Hill Ave (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Carol Ann Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-21-47

8. AGE: Years | Months | Days | If less than one day 7 hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Bowen Kieffer Jackson

13. Birthplace Balto Md

MOTHER 14. Maiden Name Patricia Damaile

15. Birthplace Cardiff Wales

16 (a) Informant Aunt (Mrs Jeanette Mitchell)

(b) Address 1324 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-22-47 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore, Md

18 (a) Funeral director Mrs Francis A. Hemsley

(b) Address 578 W. Biddle St.

19 (a) MAR 22 1947 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 21 1947, at 11 a. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 21 1947, to Mar 21 1947, and that I last saw h alive on Mar 21 1947

Immediate cause of death — Duration

Due to Atelectasis 1hr

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Otto P. Lugher M. D.

Address 825 N. Fremont Ave Date signed 3-21-47

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 3

G49864

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G49864 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2758 Fenwick Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2758 Fenwick Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JESSE H. LOMAX

3 (b) If veteran, name war --

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Laura Virginia Lomax

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 23, 1870

8. AGE: Years 76 | Months 2 | Days 27 | If less than one day hr. min.

9. Birthplace St. Mary's Co., Md.
(Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business Mickey

FATHER
12. Name Francis H. Lomax
13. Birthplace Md.

MOTHER
14. Maiden Name Almira Jackson
15. Birthplace Md.

16 (a) Informant Mrs. Annie M. Walmsley
(b) Address 2701 Alameda

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAR 22 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20, 1947, at 3:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1946 to Mar 19 1947 and that I last saw him alive on Mar 19 1947.

Immediate cause of death: Coronary occlusion — Duration: 1 day

Due to: Coronary arteriosclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature Herman L. Wardley M.D.
Address 2900 Alameda Blvd Date signed 20 March 47

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The

VS 150

G49865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G49865

Every item of information should be carefully supplied. Use correct are is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave. & Dukeland St.
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 69 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2029 Harlem Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Laura (Wid.) Sparks

3 (b) If veteran, name war --

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Albert Sparks

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 23, 1877

8. AGE: Years 69 | Months 4 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Seamstress

11. Industry or business Aetna Shirt Co.

FATHER
12. Name Thomas Cuddy
13. Birthplace Md.

MOTHER
14. Maiden Name -- McClellan
15. Birthplace Ireland

16 (a) Informant Mr. Donald Sparks
(b) Address 2029 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/24/47 (month) (day) (year)
(c) Cemetery or crematory Wesley Chapel
Location Balto. Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAR 22 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21, 1947 at 5 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 13, 1947 to March 21, 1947 and that I last saw h-- alive on March 21, 1947

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Coronary heart disease	
Due to	
Other Conditions Uremia, Prolapse of the uterus	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leon Toby M.D.
Address West Balto. Gen. Hosp. Date signed 3/24/47

VS 150

G49866

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8 2 ✓

Registered G49866

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 504 E. North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 504 E. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET F. WALTERS

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 213-10-0246

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife: Samuel S. Walters
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23, 1876

8. AGE: Years	Months	Days	If less than one day
70	10	27	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Operator-Men's Tailoring
11. Industry or business Consolidated Clothing Co.

FATHER
12. Name Cornelius F. Branen
13. Birthplace Md.

MOTHER
14. Maiden Name Sudan Mills
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Paul Walters
(b) Address 504 E. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 2 0 1947 (Date filed by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 20, 1947, at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/3 1946 to 3/20 1947, and that I last saw HER alive on 3/18 1947.

Immediate cause of death	Duration
TERMINAL PNEUMONIA	3 days
BULBAR PARALYSIS	10 days
Due to CEREBRAL ARTERIOSCLEROSIS	1 YEAR
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John H. Hirschfeld M. D.
Address 6919 Harford Rd Date signed 3/21/47

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19867

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

Registered No. G19867

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution:
Md. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 29 (If outside city or town limits, write RURAL and give town)
(d) Street No. 119 North Denison St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Leo L. Foord

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War #1	242-05-8024

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Marguerite M. Foord
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11, 1898

8. AGE: Years	Months	Days	If less than one day
48	10	9	—hr. —min.

9. Birthplace Mo (Town, county, and state)
10. Usual Occupation Supt.
11. Industry or business C. R. Daniels, Inc.

FATHER
12. Name Charles L Foord
13. Birthplace Chicago Ill

MOTHER
14. Maiden Name Green
15. Birthplace Mo.

16 (a) Informant Mrs. Margaret M. Foordd
(b) Address 119 Denison St. 29

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/24/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) MAR 28 1947 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/20/47 19 , at 9:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/5 1947 to 3/20 1947.
and that I last saw him alive on 3/20 1947.

Immediate cause of death Cardiac Respiratory failure — Duration
Due to Metastatic Carcinoma [redacted] toid
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: epidermoid carcinomatosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external cause, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. A. Mitchell M. D.
Address Md. Gen Hosp Date signed 3/20/47

VS 150

Every item of information should be carefully checked. Correct age is especially important. Physicians: please write the causes of death clearly and legibly. USE BLACK INK.

G49868

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G49868

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3945 Wilsby Ave.
(c) Hospital or institution: 91
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3945 Wilsby Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CATHERINE MARIE MARINO

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Charles Marino
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 9, 1898

8. AGE: Years	Months	Days	If less than one day
48	6	11	hr. min.

9. Birthplace Costella, Pa. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Samuel Marino
13. Birthplace Italy

MOTHER
14. Maiden Name Lucy Leone
15. Birthplace Italy

16 (a) Informant Mr. Charles Marino
(b) Address 3945 Wilsby Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/24/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md. for Wilmington Williams, Md.

19 (a) MAR 22 1947 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20, 1947, at 10:45p M

21. I certify that death occurred on the date above stated; that I attended deceased from March 6 1947 to March 20 1947, and that I last saw h.e.r alive on March 20 1947.

Immediate cause of death	Duration
Uremia	2 da.
Cerebral Hemorrhage	2 weeks
Due to Hypertensive Cardio-vascular Renal Disease	1 yr.
Due to Hemiplegia	1 yr.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank D'Virgilio M.D.
Address 1011 N. Charles St. Date signed 3/24/47 M. D.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~G49869~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G49869

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3202 Brighton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3202 Brighton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY ADA GRIFFITH

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4, 1856

8. AGE: Years	Months	Days	If less than one day
91	2	16	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Wm. Griffith
13. Birthplace Md.

MOTHER
14. Maiden Name Martha L. Morane
15. Birthplace Unknown

16 (a) Informant Mrs. John F. Calhoun
(b) Address 5 Riverside Dr., New York 22, N.Y.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/22/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 MAR 22 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20, 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 15 1946, to Mar 20 1947, and that I last saw h-er alive on 3-20 1947

Immediate cause of death — Duration
Arteriosclerotic Cardiovascular Disease - Chronic Myocarditis — Yrs.
Due to Acute Heart Failure — 2 Days
Antecedent
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Luther E. Little M. D.
Address 10 W. Madison St. Date signed 3/21/47

Luther E. Little

VS 150

G49870

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G49870

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount Aves.
(c) Hospital or institution:
Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (18)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4230 N Lochraven Blvd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Louise Dietz

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married.

6 (b) Name of husband or wife William Peter Dietz
6 (c) If alive, give age 50+ years

7. Birth date of deceased (mo., day, yr.) March 4, 1891

8. AGE: Years	Months	Days	If less than one day
56	—	16	____ hr. ____ min.

9. Birthplace Baltimore, City, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Louis W. Johnson
13. Birthplace Washington D.C.

MOTHER
14. Maiden Name Emma Virginia Smith
15. Birthplace Baltimore Md.

16 (a) Informant Deceased
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/24/47 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Cem.
Location Howard Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) ____ (Signed) (b) Hunter for Williams, M.D. (Registrar)

MAR 22 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1947 at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1947 to Mar 20 1947 and that I last saw her alive on Mar 20 1947

Immediate cause of death	Duration
Cardiac Insufficiency	7 days
Due to Cardiac Hypertrophy	10+ yrs.
Due to Hypertensive Cardio Vascular Disease	10+ yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: ____
If autopsy
Cardiac Hypertrophy, Arteriosclerosis
of autopsy: General

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature G. Allen Moulton, M.D.
Address Church Home Hosp. Date signed 3/21/47

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G13871

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G13871

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1034 N. Calhoun St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1034 N. Calhoun
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Victoria Booth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widow

6 (b) Name of husband or wife John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace Calvert Co. Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wm Wallace
13. Birthplace Md

MOTHER
14. Maiden Name Unknown
15. Birthplace " " "

16 (a) Informant Mary Lee
(b) Address 1032 N. Calhoun St

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 3-23-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location Balto. Co.

18 (a) Funeral director Isaac W. Redden
(b) Address 436 N. Biddle St.

19 (a) MAR 22 1947 (Date rec'd by registrar) (b) [illegible] Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 20 1947, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1947 to Mar 20 1947, and that I last saw h alive on Mar 20 1947

Immediate cause of death	Duration
Cerebral Hemorrhage	7
Due to	
Due to	7
Other Conditions Emphysema	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 84 Harlem Ave Date signed 3-21-47

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

19872 BC# G 54146 **CERTIFICATE OF DEATH** 13B Registered No. 19872

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 418 Hamilton Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 418 Hamilton Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Alvin Jameson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	col	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 10 46

8. AGE: Years	Months	Days	If less than one day
1	7	9	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name George Jameson
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Doris Thomas
15. Birthplace Baltimore Md

16 (a) Informant Doris Jameson
(b) Address 418 W Hamilton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 / 22 / 47 (month) (day) (year)
(c) Cemetery or crematory Mt Zion
Location Baltimore County

18 (a) Funeral director Isaiah L Brooks Son
(b) Address 1015 W Montgomery St

19 MAR 22 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1947, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 17 1947 to March 19 1947 and that I last saw h— alive on March 19 1947.

Immediate cause of death	Duration
Intracranial Hemorrhage	5 days
Due to	
Due to	
Other Conditions Pul. TB	?

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Watts M.D.
Address 515 Huntington Ave Date signed 3/22/47

VS 190

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49873

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G49873

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3206 Mordawin Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3206 Mordawin Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No) no
If yes, name country

3 (a) FULL NAME Frances P. Bucy

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	widowed

6 (b) Name of husband or wife James M. Bucy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 2. 1867

8. AGE: Years	Months	Days	If less than one day
79	5	19	hr. min.

9. Birthplace Texas.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER 12. Name James Mumford
13. Birthplace Texas

MOTHER 14. Maiden Name Martha Hull
15. Birthplace Texas

16 (a) Informant Mrs. Ollie Pratt
(b) Address 3206 Mordawin Ave

17 (a) BURIAL (b) Date thereof 3-24-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory LORRAIE-PARK
Location WOODLAWN, MD

18 (a) Funeral director G. Howard Bowling
(b) Address 320 W North ave

19 MAR 22 1947 (b) Huntington Williams, MD
(Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 21 1947 at 3P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 16 1947 to Mar 21 1947 and that I last saw h alive on Mar 21 1947

Immediate cause of death
Ch. Interstitial Hepatitis
Due to Anemia

Duration
1935
1935

Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1630 Eutaw Pl Date signed 3/24/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

STERBLING

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. 49874

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1968 Belair Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1968 Belair Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank J. Sterbling

3 (b) If veteran, name war: No.

3 (c) Social Security Account No. None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Dec 31 1887

8. AGE: Years 59 | Months 3 | Days 17 | If less than one day hr. min.

9. Birthplace Hungary (Town, County, and State)

10. Usual Occupation Monumental Worker

11. Industry or business

FATHER
12. Name Joseph Sterbling
13. Birthplace Hungary

MOTHER
14. Maiden Name Magdelina Weber
15. Birthplace Hungary

16 (a) Informant Margaret Sterbling
(b) Address 1968 Belair Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 24 47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave Rd.

18 (a) Funeral director Mat. F. E. Appel's
(b) Address 7110 Belair Rd.

19 (a) MAR 29 1947 Registered by Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1947 at 3:25 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-19 1947 to 3-20 1947 and that I last saw h[illegible] alive on 3-20 1947.

	Duration
Immediate cause of death: Lobar Pneumonia (Primary)	1 yr.
Due to: Acute dilatation of heart	10 yrs
Due to: Bronchial asthma	40 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — — — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury
23. Signature Herman Lasch, M. D.
Address 5202 Work Rd Date signed 3-21-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V S 130

G49875

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G49875

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Howard & Madison
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2003 Boone Ave # 18
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country England

3 (a) FULL NAME Thomas Patrick O'Donnell

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	214-14-5297

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Catherine O'Donnel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1, 1866

8. AGE: Years	Months	Days	If less than one day
80	9	20	hr. min.

9. Birthplace Birmingham England
(Town, county, and state)
10. Usual Occupation Special Detective
11. Industry or business May Co.

FATHER:
12. Name Thomas P. O'Donnell
13. Birthplace Ireland

MOTHER:
14. Maiden Name Catherine Meehan
15. Birthplace Ireland

16 (a) Informant Miss Margaret O'Donnell
(b) Address 2003 Boone street

17 (a) Burial (b) Date thereof 3/24/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick road

18 (a) Funeral director Chas. J. Evans Son Inc.
(b) Address 118 W. Mt. Royal Ave

19 MAR 22 1947 Huntington Williams M.D.
(Date received) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/21 1947 at 8:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-14 1947 to 3/21 1947 and that I last saw him alive on 3/21 1947

Immediate cause of death
Acute cardiac failure
Due to Intestinal Obstruction
Due to Cause undetermined - probably due to neoplasm
Other Conditions Hernia, inguinal, left, incarcerated, complete
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John E Miller M.D.
Address 1 Maryland Ave. Balto Date signed 3/21/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

49876
511910

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 ✓ Registered No. 49876

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1009 N. Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vincent R. McDonald

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male. 5. Color or race: White. 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Katherine

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) 8-5-74

8. AGE: Years 72. Months 7 Days 18 If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Bldg. - Supt. J.H.H. Medical Sch.

11. Industry or business

FATHER 12. Name ? ?

13. Birthplace ? ?

MOTHER 14. Maiden Name ? ?

15. Birthplace ?

16 (a) Informant Records.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 24 1947 (month) (day) (year)

(c) Cemetery or crematory Our Cathedral Cemetery

Location 4300 Old Frederick Rd.

18 (a) Funeral director Edwin W. Conklin & Son

(b) Address 924 E. Eager St.

19 (a) MAR 22 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1947 at 3.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 18 1947 to March 24 1947; and that I last saw him alive on March 21 1947.

Immediate cause of death: Cerebral hemorrhage — Duration: 2 da.

Due to: Arteriosclerosis generalized & arteriosclerotic

Due to: heart disease

Other Conditions: Auricular fibrillation

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cerebral hemorrhage

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. E. Salazar M.D.

Address Johns Hopkins Hosp. Date signed 3/31/47

VS 180

G19877.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G19877.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1100 Arlington Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1100 Arlington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Campbell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Widow

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1876

8. AGE: Years 70 | Months 7 | Days 10 | If less than one day hr. min.

9. Birthplace Nottaway Co. Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Richard Fowlkes
13. Birthplace Va.

MOTHER
14. Maiden Name Grace Bland
15. Birthplace Va.

16 (a) Informant Helen Fitzgerald
(b) Address 1100 Arlington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 24th (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A. A. County Md.

18 (a) Funeral director Mrs. Robt. A. Whitt
(b) Address 1129 N. Carlton St

19 MAR 22 1947 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 March 1947, at 11 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 20 March 1947 to 20 March 1947 and that I last saw h.e.r alive on 20 March 1947.

Immediate cause of death: Coronary Occlusion — Duration 1 day

Due to: Arteriosclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stanford P. Innamorato M. D.
Address 2709 Druid Hill Date signed 3-22-47

VS 150

Please write the causes of death clearly and legibly.

G49878

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G49878

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1406 Poplar Land St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1406 Poplar Land St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter Falk

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15 1878

8. AGE: Years 68 | Months 7 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Otto Falk
13. Birthplace Germany

MOTHER
14. Maiden Name Dora Mack
15. Birthplace Germany

16 (a) Informant Mrs Dora Himmelheber
(b) Address 1406 Poplar Land St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-24-1947 (month) (day) (year)

(c) Cemetery or crematory Holy Cross
Location G. A. Co. Md.

18 (a) Funeral director Flynn & Flynn
(b) Address 1426 Light St.

19 (a) MAR 22 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 110

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/24 1947, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec-1 1946, to March 1 1947, and that I last saw him alive on 3/24 1947.

Immediate cause of death	Duration
Coronary Occlusion	1 day
Due to Arterio Sclerosis	
Cardio-Vascular Renal	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Leuben M. D.
Address 320 Cathedral Street Date signed 3/25/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49879

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92

Registered No. G49879

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1806 Byrd St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1806 Byrd St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Theresa Fold

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced:
F.	W.	W.

6 (b) Name of husband or wife Adam Fold
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 7. 1862

8. AGE: Years	Months	Days	If less than one day
84	3	13	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Nicholas Keller
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Oppel
15. Birthplace Germany

16 (a) Informant Mrs Mary E. Clydesdale
(b) Address 1822 Byrd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-24-1947 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A. A. Co. Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

19 (a) MAR 22 1947 (Date rec'd by Registrar) (b) Registrar, M. D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 20 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 17 1947, to 3/20 1947, and that I last saw h[illegible] alive on 3/20/47.

Immediate cause of death	Duration
(a) Bronchitis	1 mo.
Due to — Hypostatic Congestion Collapse	2 mos.
Due to — Cirrhosis Alcoholic	6 mos.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature O. B. Wheeler M. D.
Address 1279 Pulham N. Date signed 3/22/47

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C49880

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. C49880

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 416 N Louden Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 416 N. Louden Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles Edward Butler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband~~ or wife Clara B (Kemp)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 31, 1882

8. AGE: Years	Months	Days	If less than one day
65	1	18	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Continental Can Co

FATHER
12. Name Charles Butler
13. Birthplace Md

MOTHER
14. Maiden Name Sarah Wink
15. Birthplace Md

16 (a) Informant Mrs Clara B Butler
(b) Address 416 N. Louden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 22 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location 3201 Frederick Ave

18 (a) Funeral director Davis & Wetzler
(b) Address 4101 Edmondson Ave

19 (a) MAR 22 1947 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1947, at 5.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 28 1947 to Mar 19 1947 and that I last saw h~~e~~ alive on Mar 19 1947

Immediate cause of death	Duration
Coronary Occlusion	
Due to Lobar Pneumonia	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Edward Graham Gross M.D.
Address 92 S Bigelow Ave Date signed 3/24/47

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19881

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G19881

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or ~~days~~) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City ~~or town~~ Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 935 Brooks Lane
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Moses Wiesenfeld

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of ~~husband or~~ wife Elsa K. Wiesenfeld
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24 1893

8. AGE: Years	Months	Days	If less than one day
53	8	-	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Furniture
11. Industry or business Salesman

FATHER
12. Name Joseph Wiesenfeld,
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Hattie Mann,
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Joseph Wiesenfeld II
(b) Address 935 Brooks Lane

17 (a) Burial (b) Date thereof 3/23/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto. Hebrew
Location Balto. Md.

18 (a) Funeral director Harris Levinson Sons
(b) Address 1902 Eutaw Place

19 (a) MAR 22 1947 Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/21/47 19 , at 5:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/19 1947, to 3/21 1947
I last saw him alive on 3/20 1947.

Immediate cause of death Ruptured Myocard.	Duration
Due to Coronary Thrombosis & Myocardial Infarction	
Due to Antecd. Ht disease	
Other Conditions Nephrosclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Ruptured Ht. Coronary Thrombosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leon Rosenbaum M. D.
Address Sinai Hosp. Date signed 3/24/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr Anderson
3604 Shannon Drive

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

Registered No. C49882

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3116 Weaver Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State R.I. (b) County
(c) City or town Newport (If outside city or town limits, write RURAL and give town)
(d) Street No. 61 Almy St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sara Johnson Johnson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Amanda 6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) July 28 1874

8. AGE: Years 72 | Months 7 | Days 24 | If less than one day hr. min.

9. Birthplace Sweden (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Transportation Operator

FATHER 12. Name John Johnson
13. Birthplace Sweden

MOTHER 14. Maiden Name Sara Johnson
15. Birthplace Sweden

16 (a) Informant Mrs. Elmer Johnson
(b) Address 3116 W. Weaver Ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Mar 22 1947 (month) (day) (year)

(c) Cemetery or crematory Newport
Location Rhode Island

18 (a) Funeral director Wm. Cook Inc
(b) Address 1247 St Paul St

19 (a) MAR 22 1947 (Date rec'd by registrar) (b) Huntington Wm. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1947, at 7:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 16 1947, to March 22 1947, and that I last saw h/is alive on March 22 1947.

Immediate cause of death: Coronary occlusion

Due to: Diabetes Mellitus Arterio-Sclerosis

Due to:

Other Conditions: Pulmonary Edema Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter A Anderson M. D.
Address 3001 Shannon Drive Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

3/22/47

G49883 Birth 73389

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159c

G49883 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga St.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2705 Miles Ave 11
(If rural give location)
(c) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Mullenix

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/17/47

8. AGE: Years | Months | Days | If less than one day: 1 hr. 15 min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Douglas M. Mullenix

13. Birthplace

MOTHER 14. Maiden Name Irma M. Bowers

15. Birthplace Baltimore, Md

16 (a) Informant

(b) Address

17 (a) Burial (b) Date thereof 3-20-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St. Peters
Location Baltimore, Md

18 (a) Funeral director George A. Farley

(b) Address 1800 N. Fayette St

19 MAR 22 1947 (b) Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/17/47 19 , at 6:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/17/47 19 to 3/17/47 19 ; and that I last saw him alive on 3/17/47 19 47.

Immediate cause of death: Defective Development — Duration

Due to

Due to Anencephalic Monster

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. Brinkenhoff

Address Mercy Hospital Date signed 3/18/47 M. D.

VS 150

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

G49884

G49884
AB-96919

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 2531
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr-9mos.-18days
(e) Length of stay in Baltimore (yrs., mos., or days) 61yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 911 Ridgley Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cora Theresa Roeside

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 9-1871

8. AGE: Years	Months	Days	If less than one day
75	3	12	hr. min.

9. Birthplace Pennsylvania
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry
13. Birthplace York, Pennsylvania

MOTHER
14. Maiden Name Annie Waltman
15. Birthplace Germany

16 (a) Informant Record-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) BURIAL (b) Date thereof 3 24 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory GLENHAVEN. CEM.
Location RITCHIE HIGHWAY

18 (a) Funeral director JOHN F. DENNY, INC.
(b) Address 715 LIGHT ST.

19 (a) MAR 22 1947 (b) Baltimore, Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 19 47 at 8.30A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-26- 19 45 to 3-21 19 47 and that I last saw her alive on 3-21 19 47.

Immediate cause of death	Duration
Congestive Failure	
Due to Pneumonia	
Due to	
Other Conditions Diabetes-Mellitus; Peripheral neuritis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. D. Murphy M. D.
Address Balto. City Hosp. Date signed 3-22-47

VS 150

109 B

correct as is especially important. Physicians: please write the

Baltimore City

G49885

MARYLAND STATE DEPARTMENT OF HEALTH ✓

2411 N. Charles St., Baltimore

G49885

CERTIFICATE OF DEATH 1210 Reg. Dist. No.

1. PLACE OF DEATH:

County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 200 S Fremont Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 200 S Fremont Road
(If rural, give LOCATION)

2.(a) If veteran, name war

(a) FULL NAME Sarah Catherine Ying-Lung

3. (b) Social Security Number

Sex	4. Color or race	5.(a) Single, married, widowed, or divorced
F	W	Widow

(b) Name of husband or wife Lewis G Ying Lung

6.(c) If alive, give age ..... years

Birth date of deceased (mo., day, yr.) Sept 6, 1862

AGE: Years	Months	Days	If less than one day
94	6	15	..... hrs. ..... min.

Birthplace Maryland
(Town, county, and state)

Usual occupation At Home

Industry or business

12. Name Dennis Smith

13. Birthplace md

14. Maiden name Susan C Long

15. Birthplace md

Informant James Ying Lung

Address Ellicott City Md.

Burial Date thereof 3-24-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Loudon Park.

Location Baltimore Md.

Funeral director F.C. Higinbothom

Filed 1947 Ellicott City, Md.

(Registrar) 19 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March - 21 - 1947, at 7, P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan - 16 1947, to March - 21 1947

and that I last saw h[illegible] alive on March - 21 - 1947

Immediate cause of death Chr. Interstitial Nephritis. DURATION 6 yrs

Due to

Due to Old Age

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results None Done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. Lloyd Johnson M. D. or other

Address Catonsville Md Date signed 3/20/47

X

G49886

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

G49886 Registered No.

Please write information above clearly and legibly. Physicians: please write the causes of death clearly and legibly. Cost of this is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Corner of Redwood & Greene St.
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 49 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: over
(a) State Md (b) County Baltimore
(c) City or town Freeland
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marion Eicholtz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex ~~Male~~ Female 5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Martin Eicholtz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19, 1900

8. AGE: Years 46 | Months 10 | Days 3 | If less than one day hr. min.

9. Birthplace Balto. Co. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Isaac Hollingshead
13. Birthplace Md.

MOTHER 14. Maiden Name Sally Hitchcock
15. Birthplace Md.

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 25, 1947 (month) (day) (year)
(c) Cemetery or crematory Glenelera
Location Monkton, Md.
(d) Funeral director Jacob Hartenstein
(b) Address York Rd. Freedom, Md.

Filed by registrar (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1947 at 4 49 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 27 1947 to March 22 1947 and that I last saw her alive on March 22, 1947

Immediate cause of death Lymphoma — Duration
Sarcoma with generalized Metastases

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None

of autopsy: Lymphosarcoma

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. Heyn M. D.
Address Monkton, Md. Date signed 3-22-47

G49887 BALTIMORE CITY HEALTH DEPARTMENT G49887
Registered No.

CERTIFICATE OF DEATH

81a

Please write plainly. Information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Redwood
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Allegheny
(c) City or town Cumberland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 122 South St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Bennett

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1944

8. AGE: Years	Months	Days	If less than one day
3	—	—	hr. min.

9. Birthplace Cumberland, Md. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Franklin Bennett
13. Birthplace Md.

MOTHER
14. Maiden Name Pauline Reed
15. Birthplace Md.

16 (a) Informant Mother
(b) Address Same

17 (a) Funeral (Burial, cremation, or removal) (b) Date thereof 3/24/47 (month) (day) (year)
(c) Cemetery or crematory Cumberland
Location Cumberland, Md.

18 (a) Funeral director Wilson & Son
(b) Address 127 N. Centre St.

19 (a) [illegible] (b) Huntington Williams, M.D. Registrar

23 [illegible] rec'd by reg. [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-22 1947, at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-18 1947 to 3-22 1947.
and that I last saw h[illegible] alive on 3-22 1947.

Immediate cause of death Respiratory Arrest
due to pressure on Respiratory Center
by increased intracranial pressure — Duration
Due to Chronic arachnoiditis
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 3-14-47
Major findings of operations: Chronic arachnoiditis with internal hydrocephalus
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Workman M. D.
Address Univ. Hosp. Date signed 3-22-47

VS 190

X

G49888

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G49888

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County a a
(c) City or town Annapolis Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. Tyler Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert Russell Warfield Russell Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Nellie F. Russell
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) 3/14/1895

8. AGE: Years	Months	Days	If less than one day
49	0	8	hr. min.

9. Birthplace Annapolis Md.
(Town, county, and state)
10. Usual Occupation Florist
11. Industry or business

FATHER
12. Name Edward E. Russell
13. Birthplace Annapolis Md.

MOTHER
14. Maiden Name Carrie E. Davis
15. Birthplace Annapolis Md.

16 (a) Informant H. W. Russell Jr.
(b) Address Tyler Ave Annapolis Md.

17 (a) Burial (b) Date thereof 3/25/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Mary's Cem.
Location Annapolis Md.

18 (a) Funeral director E. Miles Lamoreux
(b) Address 1003 W. Baltimore St.

(Date rec'd by registrar) (Signature) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-22 1947, at 2.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12M 3-22 1947 to 2.15 3-22 1947 and that I last saw him alive on 3-22 1947

Immediate cause of death: Pulmonary Edema & Congestive Heart Failure — Duration: 1 day

Due to: Hypertensive C.V.V.D. — Duration: Symptoms 10 yrs.

Due to:

Other Conditions: Multiple Cerebral [illegible]
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John E. Marmon
Address Zinck. Navy Date signed M. D. 3/22/47

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49889

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8 3a G49889

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & 15th
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3211 Sequoia Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Goldstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Louis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
69			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Mendle
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Louis Goldstein
(b) Address 3211 Sequoia Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-23-47 (Month) (day) (year)
(c) Cemetery or crematory Pt Covenant Memorial Park
Location

18 (a) Funeral director Jack, Lewis Inc
(b) Address 1489 E Baltimore St

MAR 23 1947 (Date received) Thurlington for Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-22 1947, at 2 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-18 1947, to 3-22 1947, and that I last saw her alive on 3-22 1947

Immediate cause of death	Duration
Cerebral Vascular Accident	
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan B. Hyman M. D.
Address Sinai Hospital Date signed 3-22-47

V S 150

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. 49890

~~G49890~~

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2818 Belmont Ave
(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2918 Belmont Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie Kauser

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name David

13. Birthplace Russia

MOTHER 14. Maiden Name Emily

15. Birthplace Russia

16 (a) Informant Wm Baltzman

(b) Address 2427 Reisterstown Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-23-47 (month) (day) (year)

(c) Cemetery or crematory Ohel Sholom

Location O'Donnell St

18 (a) Funeral director Jack Lewis Inc

(b) Address 439 E Balto St

19 (a) (Date received by registrar) Huntington Williams M.D.

MAR 25 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/21/47 19 , at 8P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/10/47 19 to 3/19/47 19, and that I last saw her alive on 3/19/47 19.

Immediate cause of death

My Cardiac

Due to Carcinoma of Breast

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
4 weeks

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter F Loos

Address 401 Edmondson Ave Date signed 3/25/47

X

G49891

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G43894 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15"
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city limits, write RURAL, and give town)
(d) Street No. 2548 Quantico Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Kesler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years 53 | Months 1 | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Manufacturer

11. Industry or business

FATHER 12. Name Dave

13. Birthplace Russia

MOTHER 14. Maiden Name Sarah

15. Birthplace Russia

16 (a) Informant Rose Kesler

(b) Address 2548 Quantico Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-23-47 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc

(b) Address 619 E Balto St

(b) Washington Boulevard

MAR 23 1947 (Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/21/47 19 at 9:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 15 19 47 to March 21 19 47 and that I last saw him alive on March 21 19 47

Immediate cause of death Cardiac failure — Duration

Due to Myocardial infarction

Due to Coronary occlusion

Other Conditions Arteriosclerosis generalized

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sidney Green M. D.

Address Sinai Hosp Date signed 3/23/47

V S 150

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49892

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G49892

Registered No. 1310

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution:
Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3415 Wabash Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Marilyn Krongard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1933

8. AGE: Years: 14 | Months | Days | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation School

11. Industry or business

FATHER
12. Name Harry Krongard
13. Birthplace Balto

MOTHER
14. Maiden Name Rita Kayser
15. Birthplace Balto

16 (a) Informant Harry Krongard
(b) Address 3415 Wabash Ave

17 (a) Burial (b) Date thereof 3-23-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Rosedale
Location Philadelphia Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1839 E Balto St

MAR 23 1947 (Huntington Willis)
(Date received by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1947 at 1:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 8 1947 to March 21 1947 and that I last saw h on alive on March 21 1947

Immediate cause of death Cardiac failure — Duration

Due to Hypertensive heart disease

Due to Chronic glomerulo-nephritis

Other Conditions Uremia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Green M. D.
Address Sinai Hospital Date signed 3/24/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G49893 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospt. 7

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3003 Oakley Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rae ~~Sborovsky~~ SOBOROVSKY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Morris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
72			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-23-47 (month) (day) (year)
(c) Cemetery or crematory Baisdale
Location Phila Rd & Hamilton Ave
18 (a) Funeral director Jack Lewis Sons
(b) Address Huntington Ave

MAR 23 1947 (Registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21, 1947, at 4 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 7 1947 to March 21 1947 and that I last saw h alive on March 21 1947.

Immediate cause of death Cardiac insufficiency

Due to Arteriosclerosis & hypertensive heart disease

Due to

Other Conditions Diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sidney Green M. D.
Address Sinai Hospital Date signed 3/24/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

927

G49891

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G49891

Registered No.

Every item of information should be carefully supplied. The street age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: 14 N. Bentalou St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) Lifetime

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 14 N. Bentalou St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME GEORGE V. GELLER

3 (b) If veteran, name war

3 (c) Social Security Account 214-01-4127

4. Sex M. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Florence

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) July 29 1876

8. AGE: Years 70 | Months 7 | Days 23 | If less than one day hr. min.

9. Birthplace Balto Md

10. Usual Occupation Paper Cutter

11. Industry or business Falconer Co.

FATHER 12. Name Henry Geller

13. Birthplace Germany

MOTHER 14. Maiden Name Helene Byng

15. Birthplace Balto Md.

16 (a) Informant F. Geller

(b) Address 14 N. Bentalou St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/26/47 (month) (day) (year)

(c) Cemetery or crematory Loudon Pk

Location Edmondson Rd

18 (a) Funeral director Geo. H. Lumbach

(b) Address 128 N. Fremont St

19 (a) Filed 3-25-1947 (b) Rec'd by registrar Washington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-21- 1947 at 6.15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-29- 1947 to 3-21- 1947 and that I last saw him alive on 3/19/ 1947

Immediate cause of death

Cardio-renal a-
Vascular disease

Duration Since 1/29/47

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature F. Geller

Address 323 Mellott Bldg Date signed M. 3 D. 3/47

VS 180

X

G49895

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G49895 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland **Sinai Hospital**
(b) Street address **Monument & Rutland Ave**
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) **45 yrs**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Md** (b) County
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **3107 Hanlon Ave**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME **Nettie Mankowitz**

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex **Female**

5. Color or race **White**

6 (a) Single, married, widowed, or divorced. **Widow**

6 (b) Name of husband or wife **Late Barney**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **1878**

8. AGE: Years **69** Months Days If less than one day hr. min.

9. Birthplace **Russia**
(Town, county, and state)

10. Usual Occupation

11. Industry or business **House Wife**

FATHER
12. Name **Isaac Kremer**
13. Birthplace **Russia**

MOTHER
14. Maiden Name **Eva ?**
15. Birthplace **Russia**

16 (a) Informant **H Mortimer Kremer**
(b) Address **3107 Hanlon Ave**

17 (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **March 23, 1947** (month) (day) (year)
(c) Cemetery or crematory **Hebrew Herring Run Cem**
Location **Bowleys Lane**

18 (a) Funeral director **Sol Levinson & Bros**
(b) Address **1124-1126 W North Ave**

19 (a) (b) **Huntington Woods, Md.**
(Date received) (Registrar)

MAR 28 1947

MEDICAL CERTIFICATION 4.25

20. DATE OF DEATH **March 22** 19 **47** at **P.** M

21. I certify that death occurred on the date above stated; that I attended deceased from **March 22** 19**47**, to **March 22** 1947, and that I last saw h**e** alive on **March 22** 19**47**

Immediate cause of death	Duration
Acute dilatation Heart	1 day
Due to Arteriosclerosis + Hypertension	3 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature **J. Frederick Lentz M. D.**
Address **Temple Gardens Apts** Date signed **3/23-47**

VS 150

X (over)

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49896

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G49896 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga.
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3142 Bayview Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Mary L. Weeder.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Mr. James Weeder
6 (c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) 4-18-13

8. AGE: Years	Months	Days	If less than one day
33 34	11	8 3	hr. min.

9. Birthplace Ontario Canada
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Duncans Mc Donal
13. Birthplace Canada
MOTHER 14. Maiden Name Mary McCormick
15. Birthplace Canada.

16 (a) Informant James L. Weeder
(b) Address 3142 Bayview Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 24 1942 (month) (day) (year)
(c) Cemetery or crematory Oaklawn
Location Eastern Ave.

18 (a) Funeral director Roland L. Fisher
(b) Address 2112 Dundalk Ave.

19 (a) Date received MAR 23 1942 (Huntington Williams, M.D. Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-21 1942, at 5 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-19 1942 to 3-21 1942 and that I last saw h[illegible] alive on 3-21 1942

Immediate cause of death	Duration
Cer. Failure	
Due to Meningococcemia	
Cerebro spinal meningitis	
Due to Meningococcus.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. Lyttens.
Address Mercy Hosp Date signed 3/21/42 M. D.

G49897

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G49897 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6530 St. Helena Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James E. Ewing.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) ~~Single~~, married, ~~widowed~~, or divorced.

6 (b) Name of husband or wife Cora Bell Ewing

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/16/84

8. AGE: Years 63 | Months 5 | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Master Mechanic

11. Industry or business Chemical Pigment Co.

FATHER 12. Name Edwin Ewing

13. Birthplace Va.

MOTHER 14. Maiden Name Sarah E. Johnson

15. Birthplace Md.

16 (a) Informant Cora Bell Ewing

(b) Address 6530 St. Helena Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 25, 1947 (month) (day) (year)

(c) Cemetery or crematory Oaklawn

Location Eastern Ave.

18 (a) Funeral director Roland L. Fuhrer

(b) Address 2112 Dundalk ave.

19 (a) APR 23 1947 (Date filed by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/22 1947, at 2:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/21 1947 to 3/22 1947 and that I last saw h.i. alive on 3/21 1947.

Immediate cause of death: Cardiac Failure — Duration

Due to Coronary Occlusion

Due to Coronary arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]

Address [illegible] Date signed 3/22/47 M. D.

X

G49898 BALTIMORE CITY HEALTH DEPARTMENT G49898
Registered No.

CERTIFICATE OF DEATH X 55E

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 51st St.
(c) Hospital or institution:
U.S.Marine Hospital, Baltimore, Md.
(d) Length of stay in hospital or inst. (~~yrs.~~, ~~mos.~~, or days) 60
(e) Length of stay in Baltimore (yrs., mos., or days) 60 days

2. USUAL RESIDENCE OF DECEASED:
(a) State [illegible] VA (b) County
(c) City or town [illegible] Norfolk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 350 E. Filer Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME DUDA, Charles Raymond

3 (b) If veteran, name war WW II
3 (c) Social Security Account No. [illegible]

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Mildred Cox Duda
6 (c) If alive, give age 42 years
7. Birth date of deceased (mo., day, yr.) Nov. 15, 1892

8. AGE: Years	Months	Days	If less than one day
54	4	7	hr. min.

9. Birthplace Bessemer, Mich.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business - - -

FATHER
12. Name Joseph Duda
13. Birthplace Bohemia

MOTHER
14. Maiden Name Elizabeth Kudil
15. Birthplace Bohemia

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Removal (b) Date thereof 3/23/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bessemer
Location Michigan
18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

(c) 28 1947 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22, 1947 at 11:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 21 1947 to Mar 22 1947, and that I last saw him alive on Mar 22 1947.

Immediate cause of death: Lymphosarcoma, Generalized — Duration ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John B. Sprigg M. D.
Address U.S. Surgeon Date signed 3-22-47

Huntington Williams, M.D.

X

G49899

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

Registered No. G49899

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts.
(c) Hospital or institution: University Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4101 Roland Ave
(If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME Rudolph Thomas

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married.

6 (b) Name of husband or wife ~~Marion Thomas~~ Marion V. Poole
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
About 72	—	—	— hr. — min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Partner of the
11. Industry or business Crescent Oil Co.

FATHER
12. Name David P. Thomas
13. Birthplace Loudon Co., Va.

MOTHER
14. Maiden Name Mary V. Thearle
15. Birthplace Trenton, N. J.

16 (a) Informant Mrs. Marion V. Thomas
(b) Address 4101 Roland Avenue

17 (a) Burial (b) Date thereof 3/25/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director H. O. Means 2nd Son
(b) Address 805 N. Calvert Street

19 (a) Katherine Williams M.H.
(Date rec'd by registrar) Registrar

MAR 23 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-22-47 19 ..., at ... M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-7- 1947 to 3-22 1947 and that I last saw him alive on 3-22- 1947

Immediate cause of death Cardiac failure — Duration

Due to Arteriosclerotic Cardiovascular disease & cardiac hypertrophy and

Due to Acute decompensation & Benign Prostatic hypertrophy

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3-13-47

Major findings of operation: Trans urethral resection O.P.H.

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles H. Hawkins M.D.
M. D.
Address University Hospital Date signed 3-22-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

X

G49900

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 106a

G49900 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1620 Elkins Lane
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 Elkins Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME John A. Phillips

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07-822

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Maggie C. Phillips (Deceased)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1, 1871

8. AGE: Years	Months	Days	If less than one day
75	9	20	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired Mineral
11. Industry or business S.S. Pensioner

FATHER
12. Name Jon H Known
13. Birthplace

MOTHER
14. Maiden Name Jon H Known
15. Birthplace

16 (a) Informant Herbert B. Phillips (Son)
(b) Address 2-W-6th Ave, Brooklyn Park, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 25, 19 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem
Location Anne Arundel Co, Md

18 (a) Funeral director A. Howard Evans
(b) Address 1400 S. Eutaw St, Balto. 30, Md.

19 (a) March 24, 1947 (b) Date received by registrar Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21, 1947, at 3:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 14 1947 to March 21 1947 and that I last saw h— alive on March 21 1947.

Immediate cause of death	Duration
Acute Dilatation of Heart	3 days
Due to Arteriosclerosis and	3 yrs. 5 mos.
Due to Acute Bronchitis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation —
of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —
23. Signature E. R. Crawford
Address 1604 Hanover St Date signed 3/21/47

VS 150

G49901 No. 109207

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G49901

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 31 N. Carey St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
William Hook Armacost

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17, 1874

8. AGE: Years 72 | Months 9 | Days 6 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Amos Armacost
13. Birthplace Md.

MOTHER
14. Maiden Name Liddy Hook
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-26-47 (month) (day) (year)
(c) Cemetery or crematory Hampstead
Location Carroll co. Md.

18 (a) Funeral director Edw. E. Tipton
(b) Address Hampstead Md.

19 MAR 24 1941 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1947, at 6.05 A.M. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 16 1947, to March 23 1947, and that I last saw him alive on Mar. 23 1947.

Immediate cause of death: Respiratory Failure — Duration
Due to: Lung Abscess, multiple, & Lung — Duration
Due to: Secondary to Pneumonia — Duration
Other Conditions — Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. R. Neuhardt M. D.
Address Balto. City Hosp. Date signed 3-28-47

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G19902

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V94a

Registered No. G19902

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Sinai Hospital
(b) Street address Monument & Rutland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1646 Thomas Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL SMITH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Nettie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 10, 1891

8. AGE: Years	Months	Days	If less than one day
55	3	12	hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation
11. Industry or business Grocer Business

FATHER 12. Name Bernard D Smith
13. Birthplace Russia

MOTHER 14. Maiden Name Sarah Weiner
15. Birthplace Russia

16 (a) Informant Bernard Smith
(b) Address 1646 Thomas Ave

17 (a) Burial (b) Date thereof March 24, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run
Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (b)
Registered by
MAR 24 1947

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/22 1947, at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/21 1947 to 3/22 1947, and that I last saw him alive on 3/22 1947.

Immediate cause of death	Duration
Uremia, Coronary Occ.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stanley N. Goffe M. D.
Address Sinai Hosp Date signed 3/22

C49903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 4/61

Registered No. C49903

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) ~~City~~ Rosewood Training Sch.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Reisterstown Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edna Ruth Sarbacker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: White | 6 (a) ~~Single, married, widow/er or divorced~~: Single

6 (b) Name of husband or wife

6 (c) If alive, give age ___ years

7. Birth date of deceased (mo., day, yr.) May 8th 1892

8. AGE: Years	Months	Days	If less than one day
54	10	12	___hr. ___min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph G. Sarbacher
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Frances C. Carroll
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Nellie M. Streeks
(b) Address 3627 Park Heights Ave.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 3/24/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 MAR 24 1947 (b) Huntington Williams M.D.
(Filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1947, at 1:40 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Colitis, acute
Hemorrhagic.

Due to

Other Conditions Diabetes mellitus
Chronic ?
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D.
Medical Examiner.
Date signed 3-21-47

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49904

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓467

Registered No. G49904

Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2796½ Alameda Blvd
(c) Hospital or institution: 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2796½ Alameda Blvd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John O Calhoun Jr

3 (b) If veteran, name war: W
3 (c) Social Security Account No. 212-10-3207

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Mary A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 2. 1880

8. AGE: Years	Months	Days	If less than one day
66	3	19	hr. min.

9. Birthplace Philadelphia Pa
(Town, county, and state)
10. Usual Occupation Stenographer Typewriter
11. Industry or business Clerk

FATHER
12. Name William J Calhoun
13. Birthplace Phila Pa

MOTHER
14. Maiden Name Ida Young
15. Birthplace Phila Pa

16 (a) Informant Mary A Calhoun
(b) Address 2796½ Alameda Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/25/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore Md
Location Baltimore Md

18 (a) Funeral director William J Ahern Jr
(b) Address 1217 E Fayette St

19 (a) MAR 24 1947 Hunting for Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1947, at 11 00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to March 1947, and that I last saw him alive on March 1 1947.

Immediate cause of death	Duration
Acute Pancreatitis & Peritonitis	2 Days
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ira E. Whitehill M. D.
Address 730 E Mount Royal Ave Date signed 3/22/47

VS 150

G49905

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G49905 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4610 Kavon ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas F. Hoarty

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-03-4594

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Margaret E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/22/06

8. AGE: Years	Months	Days	If less than one day
41	0	29	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business Delivery of Balto.

FATHER
12. Name John T. Hoarty
13. Birthplace Pa.

MOTHER
14. Maiden Name Mary L. Barnes
15. Birthplace Pa.

16 (a) Informant Margaret E. Hoarty
(b) Address 4610 Kavon ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/26/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director Williams Cook Inc
(b) Address 1217 St. Paul st

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MAR 24 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/21 1947 at 7:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/3 1947 to 3/21 1947 and that I last saw him alive on 3/21 1947

Immediate cause of death: Cardiac Failure — Duration:
Due to: Adherent pericarditis
Due to: Pericardial Effusion - Tuberculous pleural
Other Conditions with effusion.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John B Wells M.D.
Address St Joseph Hosp Date signed 3-24-47

X

G49906

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G49906

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2521 Woodbrook Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2521 Woodbrook Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Louis Weik

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of ~~husband or~~ wife: Mary Lena Weik
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8th 1870

8. AGE: Years	Months	Days	If less than one day
76	9	14	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Butcher

FATHER
12. Name Wm L. Weik Sr.
13. Birthplace Germany

MOTHER
14. Maiden Name Rosa B. Zeigler
15. Birthplace Balto. Md.

16 (a) Informant Gertrude E. Weik
(b) Address 2521 Woodbrook Ave

17 (a) Burial (b) Date thereof 3/24/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) MAR 24 1947 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 22nd 1947, at 5 45 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 20th 1945 to March 22 1947; and that I last saw him alive on Mar 19 1947.

Immediate cause of death	Duration
Myocardial Insufficiency	4 hours
Arteriosclerosis	2 yrs.
Due to Myocarditis	
Chronic Nephritis	2 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas J. Waite M.D.
M. D.
Address 532 E. 22nd St. Date signed 3/22/47

VS 150

X

G49907

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G49907 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 429 S Bond St
(c) Hospital or institution:
3 1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 429 S Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John F. Sadowski

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Dorothy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 191?

8. AGE: Years 35 | Months — | Days — | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Printer
11. Industry or business

FATHER
12. Name Ignatious Sadowski
13. Birthplace Poland

MOTHER
14. Maiden Name Mary Konyata
15. Birthplace Poland

16 (a) Informant Dorothy Sadowski
(b) Address 429 S. Bond St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 25/47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Ozmer and Co.
(b) Address 1930 Eastern Ave

19 (a) (Date) (Registrar) 3-27-47 Registrar

Huntington Williamsville, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21/47, at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 30 1946 to March 21 1947, and that I last saw him alive on March 21 1947

Immediate cause of death: Chronic Myocarditis — Duration: 2 yrs
Due to:
Due to:
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Wilbur F. Solomon M. D.
Address 129 E Biway Date signed 3/22/47

X

G43908

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1362

Registered No. G43908

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 619 Madeira St
(c) Hospital or institution:
7+
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 619 Madeira St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Andrew F. Neubert Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2 - 1904

8. AGE: Years	Months	Days	If less than one day
42	10	19	hr. min.

9. Birthplace Balto. Md. (Town, County, and state)

10. Usual Occupation Machinist

11. Industry or business

FATHER — 12. Name Andrew F. Neubert Sr.
13. Birthplace Balto. Md.

MOTHER — 14. Maiden Name Emma Hamilton
15. Birthplace Annapolis, Md.

16 (a) Informant Andrew F. Neubert Sr.
(b) Address 619 W. Madeira St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 24/47 (month) (day) (year)

(c) Cemetery or crematory Balto. Cemetery
Location North Ave + Gay St

18 (a) Funeral director John L. Miller
(b) Address 2334 Jefferson St.

19 (a) (Date rec'd by registrar) (b) Huntingtown Williamsport Md

VS 150 MAR 24 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-24-47, 1947, at 5 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1946 to Mar 1947 and that I last saw h[illegible] alive on Mar 21 1947

Immediate cause of death Pulmonary Edema — Duration 2 days

Due to Tuberculosis. — Duration 1 yr.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rachel M. Coleman M.D.
Address 3700 Park Heights Ave Date signed Mar 24/47

X

G49909

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G49909

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2312 Eutaw Place
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RUR and give town)
(d) Street No. 2312 Eutaw Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) If so, name country

3 (a) FULL NAME Eva Kohn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Morris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years 80 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER 12. Name unknown
13. Birthplace Poland

MOTHER 14. Maiden Name unknown
15. Birthplace Poland

16 (a) Informant Herman Goldstein
(b) Address 2013 Bryant Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-24-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton St

18 (a) Funeral director Jack Lewis Inc
(b) Address 1409 E Balto St

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-22 1947 at 8:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Mar 1947 and that I last saw her alive on Mar 22 1947

	Duration
Immediate cause of death: Pulmonary Edema	1 day
Due to: Coronary Thrombosis	2 day
Due to: Arteriosclerosis	20 yrs.
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Reuben N. Kolmeer M. D.
Address 3700 Park Heights Ave Date signed Mar 23 1947

VS 15 MAR 24 1947

X

49910

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G49910
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2145 Division St.
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2145 Division St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Armintey Tate

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed or divorced. widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1871

8. AGE: Years	Months	Days	If less than one day
75 76	3	23	hr. min.

9. Birthplace Md
(Town, county and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Thomas Smallwood
13. Birthplace Md

MOTHER 14. Maiden Name Sylvia Tate
15. Birthplace Md

16 (a) Informant Florence Gibbs
(b) Address 2145 Division St

17 (a) Burial (b) Date thereof 3/24/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Carroll
Location Calvert Co. Md

18 (a) Funeral director Geo. B. Kelso
(b) Address 1303 Pennsylvania Ave

MAR 24 1947

(Local registrar) (Signature of registrar)

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/20/1947, at 11:30 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 2/25/1947, to 3/20/1947, and that I last saw h[illegible] alive on 3/20/1947.

Immediate cause of death	Duration
Chronic Myocarditis -	3yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address 450 W Biddle St Date signed 3/22/47 M.D.

X

G49911

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

Registered No. G49911

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 500 ARLINGTON AVE.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 50 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 500 ARLINGTON AVE (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JANIE W. SHRIVER

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. WIDOWED

6 (b) Name of husband or wife WM. C. SHRIVER

6 (c) If alive, give age —

7. Birth date of deceased (mo., day, yr.) APRIL 13, 1866

8. AGE: Years 76 Months 11 Days 7 If less than one day hr. min.

9. Birthplace MARTINSVILLE, VA.
(Town, county, and state)

10. Usual Occupation RETIRED REGISTERED NURSE

11. Industry or business

FATHER
12. Name COL. WM. G. WERTH
13. Birthplace MARTINSVILLE, VA.

MOTHER
14. Maiden Name SUSAN WATKINS
15. Birthplace MARTINSVILLE, VA.

16 (a) Informant MR. PANNILL MARTIN (SON)
(b) Address 4 W. MELROSE AVE.

17 (a) BURIAL (b) Date thereof MARCH 24, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory PROSPECT HILL
Location TOWSON, BALTO. CO., MD.

18 (a) Funeral director Walter Burke Bradley
(b) Address 1922 W. NORTH AVENUE

19 (a) (b)
(Date rec'd by registrar)

VS 150 MAR 24 1947

Huntington for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 22, 1947, 9.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 20 MAR. 1947 to 22 MAR. 1947 and that I last saw her alive on 22 MAR. 1947.

Immediate cause of death Acute Cardiac Dilatation — Duration 3 HRS.

Due to Chronic Myocarditis — 2 YRS.

Due to —

Other Conditions Cholelithiasis — 10 YRS.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lloyd E. Saylor M. D.
Address 3902 Greenmount Ave. Date signed 23 Mar. 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49912

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 338

G49912 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1312 Longwood ST
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1312 Longwood St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wm C. Brotemarkle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Gordon Brotemarkle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30 1873

8. AGE: Years 73 | Months 8 | Days 21 | If less than one day hs. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Steel Worker

11. Industry or business Retired

FATHER
12. Name Michael Brotemarkle
13. Birthplace Md

MOTHER
14. Maiden Name Louise Linsenmeyer
15. Birthplace Pa.

16 (a) Informant Mrs. Edward Brotemarkle
(b) Address 1312 Longwood St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 24/947 (month) (day) (year)
(c) Cemetery or crematory Fort Lincoln
Location Maryland

18 (a) Funeral director Harry W. Wetzler
(b) Address 4101 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 24 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1947; at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 14 1947 to Mar 21 1947 and that I last saw h[im] alive on Mar 21 1947

Immediate cause of death Influenza — Duration 7 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. A. Lally M. D.
Address 3517 Edmondson Date signed Mar 22 1947

Burlington for Philadelphia, Pa.

X

G49913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G49913 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1328 Washington Blvd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1328 Washington Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie R. Dempler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Peter Tom Dempler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15, 1863

8. AGE: Years 83 | Months 8 | Days 5 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry Weisgerber
13. Birthplace Md.

MOTHER
14. Maiden Name —
15. Birthplace Md.

16 (a) Informant Mrs. Minnie Wormann
(b) Address 1328 Wash. Blvd.

17 (a) Burial (b) Date thereof 3/24/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave. & Longwood St.

18 (a) Funeral director Harry F. Nistler
(b) Address 401 E. Edmondson Ave

19 (a) (b)
(Date rec'd by registrar) Registrar

MAR 24 1947 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/21/47 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1/47 19 to 3/20/47 19 ; and that I last saw h alive on 3/20 19 47.

	Duration
Immediate cause of death Myocarditis	3 years
Due to Arteriosclerosis	
Due to Sen. Pet.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Helen F. Cooper M.D.
Address 401 Edmondson Ave Date signed 3/24/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V S 15

G 9914

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124B

G49914 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp'l
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1103 W. Fairmount (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Washington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace Unknown

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address Unknown

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School MAR 1 91947

18 (a) Funeral director Commissioner of Health
(b) Address

MAR 24 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-12-1947, at 2 20 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hemorrhage into Brain (Pons)

Due to Hypertensive C.V. Disease

Other Conditions Cirrhosis of Liver.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Ryan M.D. Medical Examiner.
Date signed 3-12-47

VS 181

G49915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G49915
Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hours
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 218 N. Bruce st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby BROOKS

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/21/47

8. AGE: Years	Months	Days	If less than one day
		14	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace Unknown

16 (a) Informant Unknown
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School MAR 1 91947

18 (a) Funeral director Commissioner of Health
(b) Address

MAR 24 1947 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-7- 1947, at 3 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hemorrhagic disease of new-born
Prematurity

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 3/7/47

VS 191

X

G49916

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

G49916 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 326 W. Camden St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Kennedy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	-

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Undertaker
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Johns Hopkins Medical School MAR 1 91947

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) MAR 24 1947 (Registrar) (b) Harrington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/1 1947, at 5:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Sulzinske M.D.
Medical Examiner.
Date signed 3/3/47

VS 191

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49917

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G49917

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2411 W. Lombard St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2411 W. Lombard St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Joseph Fischer

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	217.14.2122

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Nicie L. Fischer
6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) 12/31/1880

8. AGE: Years	Months	Days	If less than one day
66	2	18	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Custodian
11. Industry or business Belvedere Hotel

FATHER
12. Name Gotlie Fischer
13. Birthplace Germany

MOTHER
14. Maiden Name Gertrude Schmidt
15. Birthplace Germany

16 (a) Informant Mrs. Nicie L. Fischer
(b) Address 2411 W. Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/26/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

19 (Date received) MAR 24 1947 Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1947, at 11:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 26 1946, to Mar 22 1947, and that I last saw him alive on Mar. 22 1947.

Immediate cause of death	Duration
Aortic Dilatation Heart;	
Due to Chr. Myocarditis	
Due to	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George E. Shannon M.D.
Address 720 Medical Arts Bldg. Date signed 3/27/47

VS 150

C49918

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C49918

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2905 N. Calvert Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2905 N. Calvert Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CARL MARTIN DISTLER

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:
4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Mar. 24, 1886
8. AGE: Years 60 | Months 11 | Days 28 | If less than one day hr. min.
9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Attorney
11. Industry or business

FATHER
12. Name John C. Distler, Jr.
13. Birthplace Pa.

MOTHER
14. Maiden Name Elizabeth E. Kelber
15. Birthplace Baltimore, Maryland

16 (a) Informant Mr. Walter G. Distler
(b) Address Washington, D. C.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/25/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location Baltimore, Maryland
18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NEW AVE. & BROADWAY
MAR 24 1947
19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22, 1947, at 12 M A.M
21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 29 1940 to Jan. 30 1947, and that I last saw him alive on Jan. 30 1947

	Duration
Immediate cause of death: Coronary occlusion	Thrombosis
Due to: Coronary disease (Angina pectoris)	6½ yrs.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Henry T. Colburn M. D.
Address 2 W. Read St. Date signed 3/24/47

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 190

G49919

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G49919

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 922 N. Patterson Park Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 922 N. Patterson Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DAVID PORTER BOULDEN

3 (b) If veteran, name war	3 (c) Social Security Account
no	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Married

6 (b) Name of husband or wife Mary Cahill
6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) Feb. 21, 1860

8. AGE: Years	Months	Days	If less than one day
87	1	1	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Beth. Steel Co.
11. Industry or business Pensioner

FATHER
12. Name Wm. Boulden
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Martha Cahill
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. George S. Grayson
(b) Address 302 S. 4th. Street, Darby Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/25/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS. INC.
(b) Address Baltimore Md.

19 (a) MAR 24 1947 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 22, 1947 at 11.50A M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1943 to March 22nd 1947. and that I last saw him alive on March 21st 1947.

Immediate cause of death	Duration
Cardio Vascular renal disease	
Due to Arterio Sclerosis	
Due to Hypertension.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 3005 Wash. Blvd. Date signed 3-23-47

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49920

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

G49920 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4 N. Streeper Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4 N. Streeper Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET (MAGGIE) MILLER

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6, 1869

8. AGE: Years	Months	Days	If less than one day
77	5	16	15 hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business

FATHER
12. Name Charles Miller
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Anna Seitz
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Anna Gaigley
(b) Address 3438 Caton Avenue

17 (a) Burial (b) Date thereof 3/24/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) MAR 24 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1947, at 1.50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 16 1947 to March 21 1947, and that I last saw h[illegible] alive on March 20 1947.

Immediate cause of death	Duration
Carcinoma of the Pancreas	5 mos
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Morris W. Steinberg M. D.
Address 410 N Hilton St Date signed Mar 23 1947

VS 150

G49921

511557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G49921

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County
(c) City or town Harrisonville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME M: John Hockensmith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband Helen Hockensmith

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) 8-15-1886

8. AGE: Years 60 | Months 7 | Days 8 | If less than one day ... hr. ... min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business -

FATHER 12. Name Samuel Hockensmith

13. Birthplace Pa

MOTHER 14. Maiden Name Elizabeth Maumma

15. Birthplace Pa

16 (a) Informant Records.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 26 1947 (month) (day) (year)

(c) Cemetery or crematory Green Hill

Location Harrisonville Pa

18 (a) Funeral director J. Wilmer Sipes

(b) Address Harrisonville Pa

19 (a) MAR 24 1947 (Date rec'd by registrar) Huntingdon Pa. (b) Filed

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 23 1947, at 1 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 12 1947 to Mar 23 1947, and that I last saw h alive on Mar. 23 1947

Immediate cause of death Cerebral hemorrhage — Duration 2 da

Due to Generalized arterio-sclerosis — 15 yrs

Due to Uremia due to chronic pyelonephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Chronic pyelonephritis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. E. Salazar, M.D.

Address Johns Hopkins Hosp. Date signed 3/23/47 M. D.

correct age is especially important. Physicians: please write th... Every item of information should be carefully supplied. The ... HEADING INK. ... CAPITAL LETTERS, WITH ...

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49922

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G49922

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belvedere Hotel Charles & Chase Sts.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 75 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Belvedere Hotel. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ESTHER LEE FRIEDENWALD.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Dr. Julius Friedenwald
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16, 1866.

8. AGE: Years	Months	Days	If less than one day
80	8	7	hr. min.

9. Birthplace Richmond, Va. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Charles Rohr,
13. Birthplace Germany.

MOTHER
14. Maiden Name Sarah Rose,
15. Birthplace Germany.

16 (a) Informant Mrs. Celeste R. Hutzler,
(b) Address 270 Park Ave. New York.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 3/24/47. (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director Harris Sonnenstein Son
(b) Address 1902 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 15 MAR 24 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23rd 1947, at 3.30 p M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 5. 1943 to March 23 1947. and that I last saw h[illegible] alive on March 23. 1947

Immediate cause of death	Duration
Carcinomatosis (Segns)	6 mos
Due to Carcinoma of breast	1943
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Oct. 5 1943
Major findings of operation: Carcinoma of breast
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

Signature Louis P. Hamburger M. D.
Address 1207 Eutaw Pl Date signed Mar 23 47

X

M. D. R. 1268-6

HEALTH DEPARTMENT—CITY OF BALTIMORE

G49923 — X 937 — G49923

CERTIFICATE OF DEATH

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 533 Robert St., 14 Ward)

Registered No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 0 yrs. 2 mos. ..... ds. How long in U. S. If of foreign birth? ..... yrs. ..... mos. ..... ds.

2. FULL NAME Annie Huston

(a) Residence: No. Milford Mill Road St., ... Ward. Pikesville 8 Md.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	C	widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Nelson Huston

6. DATE OF BIRTH (month, day, year) 1864

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
83	?	?	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. —

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. —

10. Date deceased last worked at this occupation (month and year) —

11. Total time (years) spent in this occupation —

12. BIRTHPLACE (city or town) (State or country) Pikesville, Md.

FATHER

13. NAME Perry Green

14. BIRTHPLACE (city or town) (State or country) Carroll County Md.

MOTHER

15. MAIDEN NAME Mary Jane Brown

16. BIRTHPLACE (city or town) (State or country) Carroll County Md.

17. INFORMANT James Edward Green
(Address) 533 Robert St. Balto. Md.

18. BURIAL, CREMATION, OR REMOVAL
Place St. Thomas Cem. Date 3-25 19 47

19. UNDERTAKER Mr. Francis A. Stansbury
(Address) 5784 W. Biddle St

20. FILED ..... 19.....

MAR 24 1947

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 21 March 1947

22. I HEREBY CERTIFY, That I attended deceased from 15 December 1946, to 2 February 1947

I last saw h-ey alive on 2 Feb. 1947. Death is said to have occurred on the date stated above, at 7:50 A m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
1. Arteriosclerotic heart disease	

Other contributory causes of importance:

1. Hypertension	

Name of operation — Date of .....

What test confirmed diagnosis? — Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19.....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No If so, specify .....

(Signed) Charles H. Williams M. D.

(Address) 133 Reisterstown Road
X Pikesville 8, Md.

BIG CAUSE OF DEATH in plain terms, so that OCCUPATION is very important. See instructions on back of certificate.

G49324 Dect BC# P80804

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G49324 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hospital
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1918 Madison Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Campbell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/19/47

8. AGE: Years | Months | Days | If less than one day 22 hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name ?

13. Birthplace

MOTHER 14. Maiden Name Doris Campbell

15. Birthplace

16 (a) Informant Doris Campbell

(b) Address 1918 Madison Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School MAR 21 1947

18 (a) Funeral director Commissioner of Health

(b) Address

MAR 24 1947 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-19 1947, at 2A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-18 1947 to 3-19 1947 and that I last saw h[illegible] alive on 3/19 1947.

Immediate cause of death — Duration

Prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature P. Hubert Jr. M. D.

Address Univ. Hosp. Date signed 3-19-47

VS 150

X

THESE WHITE PANELS, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49925 G49925

BALTIMORE CITY HEALTH DEPARTMENT

Bl# B 73610 **CERTIFICATE OF DEATH** 1600 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 727 Mulberry St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Chew

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced Newborn

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17, 1947

8. AGE: Years | Months | Days 2 | If less than one day hr. min.

9. Birthplace Univ. Hosp. Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business Newborn

FATHER 12. Name York Kimball

13. Birthplace Bodie N.C.

MOTHER 14. Maiden Name Ruth Margaret Chew

15. Birthplace Baltimore, Md.

16 (a) Informant Ruth Chew

(b) Address 727 Mulberry St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School MAR 21 1947

18 (a) Funeral director Commissioner of Health

(b) Address

MAR 24 1947 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1947, at 9:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 17 1947, to Mar 19 1947, and that I last saw h[illegible] alive on Mar 19 1947

Immediate cause of death: Intra cranial hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. E. Smith

Address Aurora St Hospital Date signed 3/19/47

X

G49926

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BCHD 73282 / 30F

Registered No. G49926

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Redwood
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 248 Madison ave (If rural give location)
(e) Citizen of foreign country? None (Yes or No) If yes, name country None

3 (a) FULL NAME Baby Boy Jones

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/15/47

8. AGE: Years 0 | Months 0 | Days 1½ (If less than one day: 46 hr. 0 min.)

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER 12. Name Robert Bobbie Jones

FATHER 13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Thelma Hall

MOTHER 15. Birthplace Baltimore Md

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School MAR 1 91947

18 (a) Funeral director Commissioner of Health

(b) Address

MAR 24 1947 Huntington Williams, MD
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/17 1947 at 2:29 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/15 1947 to 3/17 1947, and that I last saw him alive on 3/17 1947.

Immediate cause of death Premature birth
congenital defect
of lungs & atelectasis (complete)

Due to + Tetanus

Due to Pulmonary Hemorrhage

Other Conditions + Heart disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. M. Breeden M. D.

Address Union Bldg Date signed 3/17/47

G49927

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G49927

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1602 Mc Cullough St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 Mc Cullough St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sarah Hall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife Charles C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10, 1886

8. AGE: Years	Months	Days	If less than one day
60	11	10	hr. min.

9. Birthplace Lacy Co. Va (Town, county, and state)

10. Usual Occupation Hotel proprietress

11. Industry or business

FATHER
12. Name James H. Clark
13. Birthplace Lacy Co. Va

MOTHER
14. Maiden Name Eliza Bundy
15. Birthplace Lacy Co. Va

16 (a) Informant Mr. William H. Peter
(b) Address 1602 N. Cullough St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 24, 1947 (month) (day) (year)
(c) Cemetery or crematory Lincoln Memorial Cem
Location Wash. D.C.

18 (a) Funeral director Wm. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

MAR 24 1947

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 19 47 at 7 10 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute congestive heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L. Royer M.D. Medical Examiner.
Date signed 3-24-47

G49928

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193D

G49928 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important. [illegible]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1833 McHenry St.
(c) Hospital or institution:
19

(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1833 McHenry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Leis

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 216-09-5179

4. Sex: Male | 5. Color or race: White | 6 (a) Single, ~~married, widowed, or divorced~~: Single

6 (b) Name of husband or wife: —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 29, 1878

8. AGE: Years: 68 | Months: 4 | Days: 23 2/6 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Shirt Ironer

11. Industry or business: Jewel Laundry

FATHER — 12. Name: August Reis

13. Birthplace: Maryland

MOTHER — 14. Maiden Name: Margaret Kramer

15. Birthplace: Maryland

16 (a) Informant: Mary M. Stricker

(b) Address: 1836 McHenry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/47 (month) (day) (year)

(c) Cemetery or crematory: New Cathedral Cem.
Location: Baltimore Md.

18 (a) Funeral director: George L. Pickerall

(b) Address: 2101 Frederick Ave.

19 (a) (Date received) MAR 24 1947 Huntington Williams, M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1947 at 9 A.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquest thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Hypertensive Cardiovascular disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D.
Medical Examiner

Date signed 3-24-47

G43929

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12/a

Registered No. G43929

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 627 N. Fremont Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 627 N. Fremont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Annie Williams.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John Williams.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 27, 1886

8. AGE: Years: 60 | Months: 4 | Days: 26 | If less than one day: hr. min.

9. Birthplace: Littleton N.C.
(Town, county, and state)

10. Usual Occupation: Factory worker.

11. Industry or business

FATHER
12. Name: Wyde Brown.
13. Birthplace: Littleton, N.C.

MOTHER
14. Maiden Name: Pure ?
15. Birthplace: Littleton, N.C.

16 (a) Informant: Mrs. Lallie Lassiter.
(b) Address: 627 N. Fremont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Mar 24 1949 (month) (day) (year)

(c) Cemetery or crematory: Mt. Auburn

Location

18 (a) Funeral director: Mrs. Katie R. Williams

(b) Address: 322 N. Schroeder St.

19 (a) 3-24-49 (b) (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-22-1949, 5:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/20 1949 to 3/22 1949, and that I last saw h[illegible] alive on 3/20 1949.

Immediate cause of death	Duration
Uremia Coma	
Cardio Renal disease	6 mos.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: H. A. Jackson M. D.
(Physician)

Address: 601 Madison Ave. Baltimore, Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49930

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G49930

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1312 Myrtle Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1312 Myrtle Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Georgine Marley.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	Widow

6 (b) Name of husband or wife John Marley.
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 28, 1876.

8. AGE: Years	Months	Days	If less than one day
70 68	6 7	— 23	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Brown.
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Elizabeth Johnson.
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Georgine Johnson.
(b) Address 1312 Myrtle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 24 1947
(month) (day) (year)
(c) Cemetery or crematory Mt. Auburn.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1947, at 5:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1947 to Mar 20 1947 and that I last saw h. alive on Mar 20 1947.

Immediate cause of death Cerebral Hemorrhage

	Duration
Due to	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles T. Wallis M. D.
Address 760 Park Ave. Date signed Mar 22 47

VS 150

10A Huntington Williams M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49931

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92B

Reg. G49931

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 307 N. Gilmor St.
(c) Hospital or institution: 1a
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 307 N. Gilmor St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lula Watkins.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	Widow.

6 (b) Name of husband or wife Edmond Watkins.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 25, 1889

8. AGE: Years	Months	Days	If less than one day
57	6	27	hr. min.

9. Birthplace Addlon, N. C.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Aaron Little
13. Birthplace N.C.

MOTHER
14. Maiden Name Julia Short
15. Birthplace N.C.

16 (a) Informant Mrs. Lillie Bartley
(b) Address 307 N. Gilmor St.

17 (a) Burial (b) Date thereof Mar. 25, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date received by registrar) 1947 Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1947 at 1P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/18/47 19 to 3/21 19 47, and that I last saw h Cr alive on 3/21 19 47.

Immediate cause of death Pulmonal Insufficiency — Duration 2 wks
Due to Hypertension — Duration
Due to Cardiac Decompensation — Duration
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury R. W. RECKLING

23. Signature Ralph W. Reckling M.D.
Address 426 Eastern Ave. Date signed 3/24/47

X

G49932

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No. G49932

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 806 S.Robinson Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 806 S.Robinson Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret (Maggie) Switzer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Charles Switzer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/8/1872

8. AGE: Years	Months	Days	If less than one day
74	10	14	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name John Hanna
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Schumam
15. Birthplace Maryland

16 (a) Informant Mrs. Agnes Hatton
(b) Address 806 S.Robinson Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/25/1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location O'Donnell Street, Balto.

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. Gilmor Street

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

VS MAR 24 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1947, at 5.40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 13 1947, to Mar 22 1947, and that I last saw h[illegible] alive on Mar 21 1947

Immediate cause of death	Duration
Acute Cardiac Failure	
Due to Coronary Insufficiency	
Due to	
Other Conditions Cardiac Decompensation	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. A. Flannigan M. D.
Address 3503 Eutaw Date signed 3-24-47

G43933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164E

G43933 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [redacted]
(c) Hospital or institution: Union Memorial Hospital W
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 49 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. Warrington Apts, 3908 N. Charles St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES Dorsey Warfield

3 (b) If veteran, name war: World I

3 (c) Social Security Account No. ?

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Florence A. Warfield

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 16, 1898

8. AGE: Years 49 | Months 0 | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Publisher

11. Industry or business Balto. News-Post Co.

FATHER
12. Name Chas. Dorsey Warfield
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Ella M. Cox.
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Florence A. Warfield
(b) Address Warrington Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/25/47 (month) (day) (year)
(c) Cemetery Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 24 1947 Warrington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/22 1947, at 7:25 P.M.

21. I certify that I took charge of the remains described above, held an Inquest-Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Spine and Skull

Due to

Other Conditions Crushed Chest - Fractured Left Tibia - Extensive Lacerations
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/22/47 at about 6:45 P.M.
(b) Where did injury occur? 3908 N. Charles St
(c) Did injury occur at home, on farm, industrial place, in public place? Warrington Apts While at work? No
(d) Means of injury Probably jumped from 14th floor window

23. Signature [signature] M.D.
Medical Examiner.
Date signed 3/22/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY. WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49934

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G49934

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4646 Pall Mall Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4646 Pall Mall Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES T. WILLIAMS Williams

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
None	None	M	W	Widowed

6 (b) Name of husband or wife Lillian R. Williams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 8, 1868

8. AGE: Years	Months	Days	If less than one day
78	3	13	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Myrl Wakeman- Daughter
(b) Address 3803 Flowerton Rd.

17 (a) Burial (b) Date thereof 3/25/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery Mountain View Cem.
Location Howard Co.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md

19 (a) (b)
(Date rec'd by registrar) Registrar

MAR 24 1947 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 21 1947, at 11 15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944 to Mar 21 1947, and that I last saw h[illegible] alive on Mar 21 1947.

Immediate cause of death	Duration
Myocarditis	2-3 yrs
Due to Cerebral arterio Sclerosis	5-10 yrs
Due to Senility	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. H. Wagner M.D.
Address 7 Lee Esplanade Date signed 3/24/47

X

G49935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

Registered No. G49935

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Charles & 34th Sts.
(c) Hospital or institution: 12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 78 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Charles & 34th Sts.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AUGUSTA H. MEYER

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 5, 1868

8. AGE: Years 78 | Months 11 | Days 16 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Louis G. Meyer
13. Birthplace Germany

MOTHER
14. Maiden Name Anna L. Nelker
15. Birthplace Germany

16 (a) Informant Mrs. H. E. Peterman
(b) Address Greenway Apts. #18

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/24/47 (month) (day) (year)
(c) Cemetery Loudon Pk. Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves.

19 (a) MAR 24 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 21, 1947, at 9 1/4 AM

21. I certify that death occurred on the date above stated; that I attended deceased from [illegible] 1946 to Mar. 21 1947 and that I last saw [illegible] alive on Mar. 21 1947

Immediate cause of death	Duration
Sclerosis of Lungs	2 Yrs.
Due to Coronary Occlusion Hemiplegia	1 day
Due to Cerebral Vascular Disease	5 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. J. Mann M. D.
Address 16 Bolton Street Date signed 3-24-47

VS 150

G49936

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G49936 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1014 Fawn St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1014 Fawn St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dominic Iannantuono

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 213-09-5824

4. Sex: male
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Filomena
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct. 8 1881
8. AGE: Years 65 Months 5 Days 13 4 If less than one day hr. min.
9. Birthplace Campobasso Italy (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Consolidated Eng. Co.

FATHER
12. Name Giovanni Iannantuono
13. Birthplace Italy

MOTHER
14. Maiden Name Incoronata Ciarlariello
15. Birthplace Italy

16 (a) Informant Joseph Iannantuono (Son)
(b) Address 1014 Fawn St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/25/1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Dellabiase
(b) Address 52 N. Morley St.

MAR 24 1947 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1947; at 5.15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 13 1947 to Mar. 21 1947 and that I last saw him alive on Mar. 21 1947

Immediate cause of death	Duration
Cerebral Hemorrhage	one day
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Linden M. D.
Address 14 S. Broadway Date signed 3/22/47

VS 150

G49937 BCH B 58895

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G49937 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1806 Etting Street
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1806 Etting Street (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Charles Milburn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Colored	Child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1946

8. AGE: Years	Months	Days	If less than one day
	5	11	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Horace E. Milburn
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Bertha Thornton
15. Birthplace Gloucester Co. Va.

16 (a) Informant Mrs. Milburn
(b) Address 1806 Etting Street

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 3/24/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemet.
Location Cedar Hill Md.

18 (a) Funeral director A. Hilyard
(b) Address 918 Druid Hill Ave.

MAR 24 1947 (Date filed by registrar) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-21 1947, at 10:A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-18 1947, to 3-21 1947, and that I last saw him alive on 3-21 1947

Immediate cause of death	Duration
Bronchopneumonia	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Julius S. White M. D.
Address 1802 Penna Ave Date signed 3-22-47

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 3

G49938

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1313

G49938 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1372 Fremont Ave
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1372 - Fremont Ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) **FULL NAME** Andrew Hicks

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: Colored | 6 (a) (Single) married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 54 | Months | Days | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name unknown

13. Birthplace "

MOTHER 14. Maiden Name "

15. Birthplace "

16 (a) Informant Thomas Lydon

(b) Address 321 - N. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/25/47 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Maryland

18 (a) Funeral director W. Halstead

(b) Address 918 Druid Hill ave.

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 24 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1947 at 10.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1945 to March 22 1947 and that I last saw him alive on March 18, 1947

Immediate cause of death	Duration
Pulmonary T. B.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations: None

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Silvia L. Levy

Address 23 W Fountain Place Date signed 3-22-47

Harrington Williams MD

G49939 BALTIMORE CITY HEALTH DEPARTMENT G49939
CERTIFICATE OF DEATH X 123 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Daniels Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JULIUS LANDACRE
3 (b) If veteran, name war
3 (c) Social Security Account No. 214-20-6253
4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M
6 (b) Name of husband or wife Sylvia Cornwell
6 (c) If alive, give age 19 years
7. Birth date of deceased (mo., day, yr.) July 13, 1916.
8. AGE: Years 30 | Months 8 | Days 10 | If less than one day hr. min.
9. Birthplace Near Wardensville W. Va. (Town, county, and state)
10. Usual Occupation Cotton Mill Worker
11. Industry or business C. A. Daniels Co.
FATHER 12. Name John Landacre
13. Birthplace West Virginia
MOTHER 14. Maiden Name Mary Rimer
15. Birthplace West Virginia
16 (a) Informant Mrs. Sylvia Landacre
(b) Address Daniels, Md.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 26, 1947 (month) (day) (year)
(c) Cemetery or crematory Good Shepherd
Location Ellicott City Md.
18 (a) Funeral director Easton Sons
(b) Address Ellicott City, Md.
19 (a) (b) (Permit issued by registrar) Registrar
MAR 24 1947
Huntington Williams, M.D.
VS 150

MEDICAL CERTIFICATION
20. DATE OF DEATH 3/23/1947 at 9:50 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 3/17/1947 to 3/23/1947 and that I last saw h.i.m alive on 3/22/19
Immediate cause of death Cardiac decomp: failure — Duration
Due to Mesenteric thrombosis
Due to Dangerous intestines
Other Conditions Cerebrovascular accident, multiple old fibrous lesions
(Include pregnancy within 3 months of death)
Date of operation 3/17/47
Major findings of operation: Mesenteric thrombosis & gangrenous intestines
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Robert G Rucker M. D.
Address University Hospital Date signed 3/24/47

G49940

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH v 937

G49940 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street city
(c) Hospital or institution: Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 89 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Philomena Kamphaus

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 4. 1857

8. AGE: Years	Months	Days	If less than one day
89	5	20	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Seamstress
11. Industry or business

FATHER
12. Name Rudolph Kamphaus
13. Birthplace ?

MOTHER
14. Maiden Name Annie Brennan
15. Birthplace ?

16 (a) Informant Sister Superior Sisters of the Poor
(b) Address 1200 Valley St. Balto City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof MAR. 25 1947 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 Biddle St

19 (a) (Date rec'd by registrar) MAR 24 1947 (b) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mch 24 1947, at 1230 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mch 1 1947, to Mch 24 1947, and that I last saw her alive on Mch 23 1947.

Immediate cause of death	Duration
Edema Lungs	2 days
Due to Chronic Myocarditis	3 yrs
Due to	
Other Conditions Arteno-Sclerosis	10 yrs

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E North av Date signed 3/27/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43941

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G43941 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 940 Sharp
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 940 Sharp St
(If rural give location)
(e) Citizen of foreign country? (Yes or No) V
If yes, name country

3 (a) FULL NAME Amelia Robinson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15-08

8. AGE: Years	Months	Days	If less than one day
39 38		7	hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER 12. Name John Scribner
13. Birthplace Md

MOTHER 14. Maiden Name Mary —
15. Birthplace Md

16 (a) Informant George Harvey
(b) Address 940 Sharp St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/26/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Ct
Location Balto City

18 (a) Funeral director Isaiah L. Brown Sr
(b) Address 1012 W Montgomery St

19 (a) (Date received by Registrar) (b) Filing Number Washington Williams Registrar

MAR 24 1947

VS 156

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/22/ 1947 at 1 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 10- 1947 to Mar 21- 1947 and that I last saw h alive on Mar 21 1947

Immediate cause of death	Duration
Acute Lobar Pneumonia	
Due to	
Due to V	
Other Conditions V	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James C Cooper M. D.
Address 1016 E. Sharp St Date signed 3-24-47

X

G49912

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 77c

G49912
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 103 Scott Street.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr
(e) Length of stay in Baltimore (yrs., mos., or days) 1 year

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 103 Scott Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oscar DeHaven

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Ruth Nutter DeHaven
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1895

8. AGE: Years	Months	Days	If less than one day
51 52	10	18	hr. min.

9. Birthplace Gainesboro, Va.
(Town, county, and state)
10. Usual Occupation proprietor-apt. house.
11. Industry or business

FATHER
12. Name Ruben DeHaven
13. Birthplace Virginia

MOTHER
14. Maiden Name Catherine Adams
15. Birthplace Virginia

16 (a) Informant Mrs. Ruth DeHaven
(b) Address 103 Scott St.

17 (a) Burial (b) Date thereof 3-24-47 (month) (day) (year)
(c) Cemetery or crematory Gainesboro
Location Va.

18 (a) Funeral director John O Mitchell
(b) Address Harrington Williams, Md.

19 (a) MAR 24 1947 (Date rec'd by Registrar) (b) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24, 1947, at 7.30 a M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute alcoholism

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mackie M.D.
Medical Examiner.
Date signed 3-24-47

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G49913 Registered No.

131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3945 Greenmount Ave
(c) Hospital or institution: 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3945 Greenmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Orlando Fenby

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	none

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~.
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ Wm F. Fenby
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9th 1862

8. AGE: Years	Months	Days	If less than one day
84	10	13	hr. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business Household

FATHER
12. Name David Nailz
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Carroll Co. Md.

16 (a) Informant Wm W. Renby
(b) Address 3945 Greenmount Ave.

17 (a) Burial (b) Date thereof 3/25/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) (b)
(Date rec'd by registrar) (Registrar)

MAR 24 1947
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 22nd 1947, at 6 35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1946 to 22 MAR. 1947 and that I last saw h[illegible] alive on 21 MAR. 1947

Immediate cause of death	Duration
Hypertension - Cardio-Vascular renal disease	6 mo.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lloyd E. Taylor M. D.
Address 3902 Greenmount Ave. Date signed 22 MAR. 1947

X

G49944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 8 3a

G49944 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 628 E. Fort Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 628 E. Fort Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Addie E. Slater

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: William B. Slater

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13, 1880

8. AGE: Years 66 | Months 10 | Days 10 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Charles Schooler
13. Birthplace Virginia

MOTHER 14. Maiden Name Unknown Unknown
15. Birthplace Unknown

16 (a) Informant Genevieve L. Dawson
(b) Address 628 E. Fort Ave

17 (a) Burial, cremation, or removal (b) Date thereof 3/24/47 (month) (day) (year)
(c) Cemetery or crematory Kilmarnock
Location Kilmarnock Va

18 (a) Funeral director Wilson & Son
(b) Address 1214 E. Cold St.

19 (a) (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1947, at 12 45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-15 1947, to 3-23 1947, and that I last saw her alive on 3-23 1947

Immediate cause of death	Duration
Cerebral Hemorrhage	1 wk
Due to Arteriosclerosis	2 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. S. Tolliod M. D.

Address 707 Fort Ave. Date signed 3-24-47

VS 150

X

G49915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G49915 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 803 W. Cross Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: JOSEPH W. DITTLEMEYER

3 (b) If veteran, name war: World War #II

3 (c) Social Security Account No. 212-16-6494

4. Sex: Male

5. Color or race: White

6 (a) Single, married, ~~widowed~~ ~~divorced~~: Married

6 (b) Name of husband or wife: Gertrude Dittlemeyer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 2, 1900

8. AGE: Years 46 47 | Months 5 | Days 20 | If less than one day hr. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation: Leather Dyer

11. Industry or business: T. J. O'connor & Sons

FATHER
12. Name: (Unknown) Dittlemeyer
13. Birthplace: "

MOTHER
14. Maiden Name: Unknown
15. Birthplace: "

16 (a) Informant: Gertrude Dittlemeyer
(b) Address: 803 W. Cross St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-25-47 (month) (day) (year)
(c) Cemetery or crematory U. S. National
Location Baltimore, Md.

18 (a) Funeral director: William Cook, Inc.
(b) Address: 1217 St. Paul Street

19 (a) 1941 (Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH March 22 19 47 at 9:15 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary artery disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D. per [illegible] M.D.
Medical Examiner.
Date signed 3-22-47

VS 151

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49946

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G49946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1221 N. Dallas St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Left
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1221 N Dallas St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22 1870

8. AGE: Years: 77 | Months: 1 | Days: 1 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER — 12. Name Richard Smith Sr.
13. Birthplace Md

MOTHER — 14. Maiden Name Harriet Moody
15. Birthplace Md

16 (a) Informant Melvin Smith
(b) Address 1221 N. Dallas St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-26-47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Balto. Co.

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 1: MAR 24 1947 Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-23 1947 at 11:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from — 19— to — 19—, and that I last saw h— alive on — 19—.

	Duration
Immediate cause of death Amputated	
Coronary thrombosis	
Due to arteriosclerosis	
Due to Gangrene	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Howard Traynor M. D.
Address 1623 E. N. Ave Date signed 3-25-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C42917 / 83a — Registered No. C42917

C42917

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2718 Englewood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2718 Englewood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert L. Miller

3 (b) If veteran, name war —

3 (c) Social Security Account No 212-09-2600

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Theresa Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1 - 1873

8. AGE: Years	Months	Days	If less than one day
73	6	22	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Chemist
11. Industry or business Drugs

FATHER
12. Name Wm F. Miller
13. Birthplace Md

MOTHER
14. Maiden Name Mary Peddicord
15. Birthplace Md

16 (a) Informant Mrs. Herbert Norris.
(b) Address 2718 Englewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 27 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) (Date rec'd by registrar) Washington Millimore Registrar

MAR 24 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1947, at 10:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/28 1947 to 3/23 1947
and that I last saw h/M alive on 3/22 1947

Immediate cause of death	Duration
LEFT HEMIPLECIA	2 MOS
CEREBRAL HEMORRHAGE	2 MOS
HYPERTENSIVE VASCULAR	
Due to DISEASE →	15 YRS
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John H. Burgdorfer M.D.
Address 6919 Harford Rd Date signed 3/24/47

X

G49918 — BALTIMORE CITY HEALTH DEPARTMENT — G49918 Registered No.

CERTIFICATE OF DEATH 46 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 309 So Sayon
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 309 S. Sayon (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Florence G. Haire

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: late Edward L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12 1874

8. AGE: Years 67 | Months 11 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation House work
11. Industry or business at home

FATHER
12. Name Henry Behrens
13. Birthplace Germany

MOTHER
14. Maiden Name Waltemire
15. Birthplace Maryland

16 (a) Informant Mrs Maud F. Walston
(b) Address 309 So. Sayon St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/25/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave

18 (a) Funeral director John F. Conway & Son
(b) Address 901 Hollins Street

19 (a) 1947 (b) [illegible] Registrar
Received by registrar 21 1947
Washington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/22/1947, at 6:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 8th 1947 to Mar 22 1947, and that I last saw her alive on Mar 22 1947.

Immediate cause of death: Carcinoma of Stomach with Metastasis to Liver — Duration: Undetermined
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alfred Cole
Address 1934 Hollins Ave Date signed 3-25-47 M.D.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49949

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registration No. G49949

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2935 Pulaski Hwy.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 1/2
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2935 Pulaski Hwy.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa Scurto

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Michelangelo Scurto

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15/1862

8. AGE: Years 85 | Months 2 | Days 7 | If less than one day hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER — 12. Name — Cinquegrani
13. Birthplace Italy

MOTHER — 14. Maiden Name ?
15. Birthplace Italy

16 (a) Informant Mrs. Jos. Petrone
(b) Address 2935 Pulaski Hwy.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 26 47 (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Aliceno St

19 (a) (Date received by registrar) MAR 24 1947 (Signature of registrar) Evelyn Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 22 1947, at P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/10 1946, to 3/22 1947, and that I last saw h[illegible] alive on 3/22 1947

Immediate cause of death: Pulmonary Oedema — Duration: 10 hours

Due to: Cardio Vascular Renal — Duration: ?

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. J. Faulkner M. D.
Address 100 N. Mulberry Date signed 3/24/47

VS 150

G49950

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 90 B

G49950 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Fulton Avenue
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3105 Clifmont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Michael J Mc Grath

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary L (nee

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 8, 1874

8. AGE: Years 73 | Months 2 | Days 13 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Michael Mc Grath
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Enright
15. Birthplace Ireland

16 (a) Informant Attending Phy Mc Grath
(b) Address 3105 Clifmont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/24/47 (month) (day) (year)

(c) Cemetery or ~~crematory~~ Holy Redeemer
Location 4430 Belair Rd. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) (Date rec'd by registrar) (b) Registrar

VS 15 MAR 24 1947 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1947 at 6.50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19

	Duration
Immediate cause of death: Cardiac Failure	
Due to: Pericardial effusion	
Due to: Bronchiectasis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hamilton Smith Jr M. D.
Address St Agnes Hosp Date signed 3/21/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49951

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 62

G49951 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens ave at Caton.
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1907 Grinnalds ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Margaret Meyers (Myers)
3 (b) If veteran, name war
3 (c) Social Security Account No. 217-16-[illegible]

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Charles H. Meyers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/9/1902

8. AGE: Years 44 | Months 11 | Days 2 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George Dietz
13. Birthplace Md

MOTHER
14. Maiden Name Mary Whipple
15. Birthplace Md.

16 (a) Informant Family
(b) Address 1907 Grinnalds Ave

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 3-25-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Brooklyn, Md.

18 (a) Funeral director J. H. Caney
(b) Address 130 S. Fort Ave

19 (a) MAR 24 1947 (Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/21/1947 at 1115 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/23/1947 to 3/21/1947
and that I last saw h[illegible] alive on 3/21/1947
Immediate cause of death Cardiac failure
Adenoma of the pituitary
Secondary pleurisy
Due to N.C.D.
Due to arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address [illegible] Date signed 3/24/47

VS 150

G49952

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

G49952 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Eutaw Ave.
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 Kentucky Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilhelmina M. Reinking

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife George J. (Dec'd)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 10-1873

8. AGE: Years 74 | Months 2 | Days 13 | If less than one day hr. min.

9. Birthplace Balto-Md.
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER 12. Name Charles Kittie

13. Birthplace Germany

MOTHER 14. Maiden Name Sophia Eck.

15. Birthplace Germany

16 (a) Informant Mrs. Helen Filbeskey

(b) Address 2101 Kentucky Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) 3 (day) 26 (year) 47

(c) Cemetery or crematory Parkwood

Location Balto

18 (a) Funeral director Leonard J. Kyck

(b) Address 5305 Harford Road

19 (a) (Date received) MAR 24 1947 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/23 19 47, at 9:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/19 19 47, to 3/23 19 47 and that I last saw h[illegible] alive on 3/22 19 47

Immediate cause of death	Duration
Resp. Failure	
Due to Adenocarcinoma ovary with metastases	
Due to	
Other Conditions Left hydrothorax	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry W. Hollyes M. D.

Address St's Agnes Hosp Date signed 3-23-47

X

G49953

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G49953

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 530 S Belnord Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 530 S Belnord Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Wheeler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Charles H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 8 1885

8. AGE: Years	Months	Days	If less than one day
62	1	14	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business Housewife

FATHER
12. Name Wm F Myers
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary Lutz
15. Birthplace Germany

16 (a) Informant Charles H. Wheeler
(b) Address 530 S Belnord Ave

17 (a) Burial (b) Date thereof 3/27/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave Rd

18 (a) Funeral director John A Horan
(b) Address 3600 E Baltimore St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1947 at 9-16P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 13 1947 to Mch 22 1947 and that I last saw her alive on Mch-21- 1947

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Chronic Myocarditis	5 yrs
Due to	
Other Conditions Diabetes Mellitus	10 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M. D.

Address 1621 E. North Ave Date signed 3/23/47

V.S. 130 MAR 24 1947 Huntington Williams, M.D.

927

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G49954

Registered No. G49954

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 102 S. Ellwood
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 102 S. Ellwood Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Adam Frank Dunkie

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Eleanora Dunkie
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) May 31 1883

8. AGE: Years	Months	Days	If less than one day
63	9 10	22	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Wood Finisher
11. Industry or business Piano Mfg.

FATHER
12. Name George Sawicki
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Eleanora Dunkie
(b) Address 102 S. Ellwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/26/47 (month) (day) (year)
(c) Cemetery or crematory Holy Red.
Location Belair Rd.

18 (a) Funeral director John C. Moran
(b) Address 3060 E. Baltimore St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1947, at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 24 1946, to March 22 1947, and that I last saw h(er) alive on March 21 1947.

Immediate cause of death	Duration
Myocardial Degeneration	
Due to Cause Unknown	
Due to	
Other Conditions Unknown	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles L. MacMenamin M. D.
Address 2911 E. Balto St. Date signed March 24, 1947

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G49955 Registered No. G49955

G49955

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~2536 LIBERTY PARKWAY~~ CALVERT AND SARATOGA
(c) Hospital or institution: MERCY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 MOS. 21 DYS
(e) Length of stay in Baltimore (yrs., mos., or days) 28 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Baltimore
(c) City or town BALT. Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2536 LIBERTY PARKWAY
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret L Minahan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/19/1882

8. AGE: Years	Months	Days	If less than one day
65	2	2	hr. min.

9. Birthplace PA.
(Town, county, and state)

10. Usual Occupation HWF.

11. Industry or business —

FATHER
12. Name THOMAS McGOVERN.
13. Birthplace IRELAND.

MOTHER
14. Maiden Name ROSE MEEHAN
15. Birthplace PA IRELAND.

16 (a) Informant Paul Tillmann
(b) Address 2536 Liberty Parkway

17 (a) Burial (b) Date thereof 3/25/57
(Burial, cremation, or removal) (Month) (day) (year)
(c) Cemetery or crematory Holy Rood
Location Belair Rd.

18 (a) Funeral director John J. Mahan
(b) Address 4261 Hammond Ln

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 24 Washington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-21 1957, at 11:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from NOV. 30 1956 to MARCH 21 1957; and that I last saw her ALIVE on 3-21 1957:

Immediate cause of death	Duration
RESP. FAILURE	
Due to PNEUMONIA RT. LUNG	
Due to	
Other Conditions CARCINOMA STOMACH WITH METASTASIS.	

(Include pregnancy within 3 months of death)

Date of operation 3-22-57

Major findings of operations INOPERABLE CARCINOMA STOMACH.

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James A. Roberts M. D.
Address Mercy Hospital Date signed 3-21-57

X

G49956

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

✓ G49956 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 4+
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 24 Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Nikolai Mikoczorke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years	Months	Days	If less than one day
59			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School MAR 1 91947
Commissioner of Health

18 (a) Funeral director
(b) Address

19 MAR 24 1947 (Date filed by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/6 1947, at 7:30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Glomerular Nephritis
Due to Chronic Cardiac

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. L. Sulzbacher M.D. Medical Examiner.
Date signed 3/9/47

VS 131

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49957 ✓ G49957

BALTIMORE CITY HEALTH DEPARTMENT.

CERTIFICATE OF DEATH 13B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1412
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Fe Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theodore Ralls

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1917

8. AGE: Years 30 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace Unknown

MOTHER 14. Maiden Name

15. Birthplace Unknown

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School MAR 19 1947

18 (a) Funeral director Commissioner of Health

(b) Address

(c) MAR 24 1947 (registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7, 1947, at 1.22 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bacterial Pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Earl B. Ryan M.D. (Medical Examiner)

Date signed 3/8/47

VS 181

correct age is especially important. Physicians please write the

G49958

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G49958

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 752 E. Fort Ave DOA
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 752 E Fort Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pearl Spies

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married (Louis Spies)

6 (b) Name of husband or wife
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Aug 19-1883

8. AGE: Years	Months	Days	If less than one day
63	7	4	hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Dont Know
11. Industry or business

FATHER	12. Name Marshall Mead
	13. Birthplace Dont Know
MOTHER	14. Maiden Name Dont Know
	15. Birthplace Dont Know

16 (a) Informant Mr. And Mrs. Schmidt
(b) Address 222 Mt Olivet Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 26- (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery City
Location

18 (a) Funeral director Lillard Funeral Home
(b) Address 2508 Orleans St

19 (a) (Date received by Registrar) (b) Huntington Williams Registrar

MAR 24 1947

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/23 1947 at 3:55 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature R. L. Sutherland M.D.
Medical Examiner.
Date signed 3/24/47

X

JL - 6419959

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 111a

Registered No. G43548

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 32 days
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1610 Thames St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Misiuk

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Helen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 27, 1880

8. AGE: Years	Months	Days	If less than one day
66	10	24	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Theodore Misiuk
13. Birthplace Poland

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-25-47 (month) (day) (year)
(c) Cemetery or crematory Holy Trinity Russian
Location Stoney Run, Md.

18 (a) Funeral director Joseph Griffin & Son
(b) Address 423 S. Paca St.

19 (a) Filed (Date Registered) 1947 (b) Registrar Huntington Hall, Md.

MEDICAL CERTIFICATION P. M.

20. DATE OF DEATH March 21 1947, at 10.20

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 17 1947, to March 21 1947, and that I last saw h im alive on March 21 1947

Immediate cause of death: Respiratory Failure — Duration

Due to: Pulmonary Infarction

Due to:

Other Conditions: Generalized Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: Yes - Beth City Hosp

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. S. Purkerson M. D.
Address Beth. City Hosp. Date signed 3-22-47

Examiner.

VS 150

G49960 BC#1983315

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

G49960

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital, Baltimore Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) N
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 424 W. Camden St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** GLORIA JEAN SMITH

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex 7 | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 29-1947

8. AGE: Years | Months 1 | Days 23 | If less than one day 25 hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Richard Eugene Smith
13. Birthplace Va

MOTHER
14. Maiden Name Kate Carmel
15. Birthplace Va

16 (a) Informant Richard E. Smith
(b) Address 424 W. Camden St

17 (a) Burial (b) Date thereof 3-22-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Carmel Cemetery
Location Carmel, Virginia

18 (a) Funeral director John A. Gretbauckas
(b) Address 423 S. Paca St

19 (a) (b)
(Date rec'd by registrar) Registrar

V S 150 MAR 24 19 Huntington Maryland

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1947, to March 23 1947, and that I last saw her alive on March 23 1947

Immediate cause of death Diarrhea — Duration

Due to

Due to

Other Conditions Premature
Upper Respiratory Infection
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S A Warren M. D.
Address Sinai Hospital Date signed Mar 24 1947

G43961

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 156 B

G43961

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & Calhoun
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4614 Hampden Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Evelyn Sue Bishoff

3 (b) If veteran, name war: N

3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Duncan C. Bishoff

6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) 6/23/1908

8. AGE: Years 38 | Months 9 | Days 1 | If less than one day: hr. min.

9. Birthplace W. Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Edward Rockwell
13. Birthplace W. Va

MOTHER
14. Maiden Name Mary Hoyle
15. Birthplace W. Va

16 (a) Informant Duncan C. Bishoff
(b) Address same

17 (a) Funeral (Burial, cremation, or removal) (b) Date thereof 3/26/47 (month) (day) (year)
(c) Cemetery or crematory Greenlawn Memory Gardens
Location Greenlawn Memory Gardens W. Va

18 (a) Funeral director Wilford H. Dorsey
(b) Address 1217 W. Fayette St.

19 (a) 3/24/1947 (Date received by registrar) Washington Williamson, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/24/1947, at 12:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/24/1947 to 3/24/1947, and that I last saw he alive on 3/24/1947

Immediate cause of death: Cardiac decompensation — Duration: 3 days
Respiratory failure — 2 days
Due to Bronchopneumonia, grippal
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stanley B. Klyanowicz M.D.
Address Franklin Square Hosp. Date signed 3/24/47 M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G49962

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 180

G49962
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1
(c) Hospital or institution: Mercy 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1212 St. Paul St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN PATTERSON PETTYJOHN

3 (b) If veteran, name war	3 (c) Social Security Account No.
Unknown	?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1913

8. AGE: Years	Months	Days	If less than one day
33	8	0	hr. min.

9. Birthplace Lynchburg, Va. (Town, county, and state)
10. Usual Occupation Interior Decorator
11. Industry or business

FATHER
12. Name Albert Dorain Pettyjohn
13. Birthplace Lynchburg, Va.

MOTHER
14. Maiden Name Irene Meals
15. Birthplace Roanoke, Va.

16 (a) Informant John M. Oakey, Fun'l Dir.
(b) Address Roanoke, Va.

17 (a) Removal (b) Date thereof 3/24/46 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery ~~xxxxxxxx~~ Evergreen Cemetery
Location Roanoke, Va.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves Balto. 17, Md.

19 (a) (b)
(Date received by registrar) Registrar

MAR 24 1947
Hunting for Williams, MD

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/23/47 19, at 6:A.M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH 3rd° Burns, 100% of body

Due to Fire

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/23/47 at 11/2 P.M. 4:00 A.M.
(b) Where did injury occur? 1212 St. Paul St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fire Accidental Burns

23. Signature [signature] M.D.
Medical Examiner.
Date signed 3/23/47

G49363

CWK-104966

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 136

G49363 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5- 22-
(e) Length of stay in Baltimore (yrs., mos., or days) 21- 1- 0-

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1017 N. Kenwood Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Evelyn Marshall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 24-1926

8. AGE: Years 21 | Months 1 | Days 0 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Earl Marshall
13. Birthplace Maryland

MOTHER
14. Maiden Name Virginia Cahey
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue 3/28/47

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Wilhelm Bok Jr
(b) Address 1219 E. Fort Ave

19 (a) MAR 25 1941 (Date rec'd by registrar) (b) Burying for Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 19 47, at 10:30 A

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 2 19 46, to Mch. 24 19 47, and that I last saw her alive on Mch. 24 19 47

	Duration
Immediate cause of death: Shock	15 min
Due to: Operation	
Due to: Pulmonary tuberculosis Far advanced	24 yrs
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation 3-24-47

Major findings of operation: as above

of autopsy: 0

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J. Orrell M. D.
Address Balto. City Hosp Date signed 3-29-47

VS 150

C49964

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

Registered No. C49964

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 901 Beaumont Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 901 Beaumont Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Olive Bennett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Rev. L. Emory
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17, 1882

8. AGE: Years	Months	Days	If less than one day
65	0	6	hr. min.

9. Birthplace Patapsco Neck, Balto. County, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own home

FATHER
12. Name John Franklin Murray
13. Birthplace Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Lunsford Emory Bennett
(b) Address 901 Beaumont Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/26/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 MAR 25 1947 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mch 23 1947, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 7 1946, to Mch 23 1947, and that I last saw h[illegible] alive on Dec 23 1947.

	Duration
Immediate cause of death: Cerebral hemorrhage No attack	5 days
Due to: Hypertension	years
Due to:	
Other Conditions: Cerebral hemorrhage	1929

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jno A Entwisle M. D.
Address 12 E Eager St Date signed Mch 24/47

VS 150

G49965

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. 049965

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 227 E. North Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 227 E. North Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Blossym Marie Watkins

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-10-5270

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Perry M. Watkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 9, 1884

8. AGE: Years	Months	Days	If less than one day
63	0	14	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Harry Zell
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Mary C. Shanon
15. Birthplace Pennsylvania

16 (a) Informant Perry M. Watkins
(b) Address 227 E. North Avenue

17 (a) cremation (Burial, cremation, or removal) (b) Date thereof 3/26/47 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 MAR 25 1947 (Date received by registrar) (b) Huntington Wit... Given, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mch-23- 1947; at 7-15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mch 17- 1947 to Mch 23 1947 and that I last saw h.e alive on Mch 23 1947.

Immediate cause of death	Duration
Carcinomatosis	2 months
Due to Carcinoma of Uterus	5 mos
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E North Ave Date signed 3/24/47

G49966

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G49966

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT AND SARATOGA
(c) Hospital or institution:
MERCY HOSPITAL 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 84 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County -------
(c) City or town BALT. 6
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2445 N. CHARLES ST.
(If rural give location)
(e) Citizen of foreign country? ----- (Yes or No)
If yes, name country -------

3 (a) FULL NAME MISS SARAH P CORCORAN

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) -------- 1863

8. AGE: Years	Months	Days	If less than one day
84	--	--	-- hr. -- min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business -----

FATHER
12. Name Frank Corcoran
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name RACHEL SHEPPARD
15. Birthplace Baltimore Co., Md.

16 (a) Informant J. Neil Corcoran
(b) Address 2816 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/25/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director W. W. Mears and Son
(b) Address 805 N. Calvert Street

MAR 25 1947 (Date rec'd by registrar) (b) Hartley for Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-23-47 1947, at 12:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-19 1947, to 3-23 1947, and that I last saw HER alive on 3-23 1947.

Immediate cause of death CARDIAC FAILURE. — Duration

Due to CONGESTIVE CARDIAC FAILURE

Due to ARTERIOSCLEROTIC HEART DISEASE

Other Conditions HYPERTENSION

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James A. Roberts M. D.
Address Mercy Hospital Date signed 3-23-47

X

G49967

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G49967

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2210 N. Charles St.
(c) Hospital or institution: ----------
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 ----
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ----------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2210 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? ---------- (Yes or No)
If yes, name country ----------

3 (a) FULL NAME F. Joseph Kuper

3 (b) If veteran, name war ----------
3 (c) Social Security Account No. ----------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ###### wife Caroline M. Cramer
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) March 5, 1877

8. AGE: Years	Months	Days	If less than one day
70	0	18	--- hr. --- min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Secretary
11. Industry or business ----------

FATHER
12. Name Michael Kuper
13. Birthplace Baltimore

MOTHER
14. Maiden Name Margaret Neisendorfer
15. Birthplace Baltimore

16 (a) Informant Mrs. Caroline M. Kuper
(b) Address 2210 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/26/47 (month) (day) (year)
(c) Cemetery ####### Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director H. H. Meare & Son
(b) Address 805 N. Calvert St.

19 (a) MAR 25 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 MARCH 1947, at 1:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 17 MARCH 1947, to 23 MARCH 1947, and that I last saw him alive on 23 MARCH 1947.

Immediate cause of death	Duration
Due to Coronary Thrombosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lloyd C. Taylor M. D.
Address 3902 Greenmount Ave. Date signed 25 MAR 47

G49368

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. G49368

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2 Queenspring Ave
(c) Hospital or institution: Levendale
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 19 Levendale (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME REBECCA ALTMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Louis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name unknown

13. Birthplace Russia

MOTHER 14. Maiden Name unknown

15. Birthplace Russia

16 (a) Informant Max Goldyn

(b) Address 2916 Springhill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-25-47 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Philadelphia-Hamilton Ave

18 (a) Funeral director Jack Lewis Inc

(b) Address 1816 Bath St

19 (a) Filed MAR 25 1947 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-24 1947 at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-16 1946 to 3-24 1947 and that I last saw her alive on 3-24 1947

Immediate cause of death Chronic cardiovascular disease — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry N Zyl M. D.

Address Levindale Home Date signed 3-24-47

VS 150

G49969

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G49969

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3207 Southern Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3207 Southern Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret J Nichols

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Harry D Nichols
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 4-29-1866
8. AGE: Years 80 | Months 10 | Days 23 | If less than one day hr. min.
9. Birthplace Penna (Town, county, and state)
10. Usual Occupation at Home.
11. Industry or business

FATHER
12. Name Charles T Hawthorn
13. Birthplace Penna

MOTHER
14. Maiden Name Mary A Dawson
15. Birthplace Penna

16 (a) Informant Miss Nellie Hawthorn
(b) Address 3207 Southern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Loughran Funeral Home
(b) Address 7401 Belair Road

19 MAR 25 1941 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1947 at 7.55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 25 1947 to March 23 1947 and that I last saw her alive on March 23 1947

	Duration
Immediate cause of death: Pneumonia	2 days
Due to: Chronic Interstitial Nephritis	4 years
Due to: Chronic Myocarditis	3 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation None
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury None

23. Signature L. T. Grundy MD M. D.
Address 5106 Harford Rd Date signed 3/24/47

VS 150

G49970

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G49970

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2928 N. Calvert St.
(c) Hospital or institution:
none 12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2928 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Janet Colton Shearer

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 18, 1873

8. AGE: Years	Months	Days	If less than one day
73	11	5	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Wm. Shearer
13. Birthplace Scotland

MOTHER
14. Maiden Name Agnes Carr
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Lillian A. Shearer
(b) Address 2928 N. Calvert St.

17 (a) Burial (b) Date thereof 3/26/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~cemetery~~ Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 Eutaw Place

19 (a) MAR 25 1947 (b) Hunting for Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1947, at 10:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1947 to Mar. 23 1947 and that I last saw her alive on Mar. 23 1947.

Immediate cause of death Coronary Thrombosis — Duration 7 days

Due to myocarditis, chronic — 20 Yrs

Due to Arteriosclerosis — 10 Yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work
(Specify which place)
(e) Means of injury

23. Signature William A. Sexton M. D.
Address 2824 St. Paul St. Date signed 3-24-47

VS 150

G49971

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G49971

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 10-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1034 Central Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Wm. Busch.
3 (b) If veteran, name war
3 (c) Social Security Account No. 219 01 2872

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Mary E Busch (Redgrave)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16 1868

8. AGE: Years	Months	Days	If less than one day
78	9	7	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Clerk.
11. Industry or business U.S.F.D. Inc

FATHER
12. Name Conrad Busch
13. Birthplace Germany

MOTHER
14. Maiden Name Sophia Koehler
15. Birthplace Germany

16 (a) Informant George A Busch
(b) Address 1318 E. Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 26 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balto Md

18 (a) Funeral director J. Melville Jenkins.
(b) Address 2713 Kirk Ave

19 (a) MAR 25 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/23 1947, at 10:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/13 1947 to 3/23 1947; that I last saw h[illegible] alive on 3/23 1947

Immediate cause of death Carcinoma of Liver

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Carcinoma of liver

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address Sinai Hosp Date signed 3/24 M.D.

V S 150

X

G49972

LAKE

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. G49972

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1102 N Mount St
(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1102 N. Mount (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maggie Lake

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Benjamin Lake
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27 1871

8. AGE: Years 75 | Months 9 | Days 26 | If less than one day hr. min.

9. Birthplace Carroll Co Md (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Thomas Brown
13. Birthplace Md

MOTHER
14. Maiden Name Margaret Stewart
15. Birthplace Md

16 (a) Informant Benjamin Lake
(b) Address 1102 N Mt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-30-47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto

18 (a) Funeral director George G. Nelson
(b) Address 1303 Pennsylvania Ave

19 MAR 25 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1947, at 2:4 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 16 1947, to March 22 1947, and that I last saw h alive, on March 22 1947.

Immediate cause of death: a Pulmonary Hemorrhage — Duration: 9

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 1102 N Mount Date signed March 25 1947

X

C49973

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C49973

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1217 W. Lanvale St
(c) Hospital or institution: No

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County –
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1217 W. Lanvale St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Florence Clemmons

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Colored	Widowed

6 (b) Name of husband or wife Simon Clemmons
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 7, 1876

8. AGE: Years	Months	Days	If less than one day
71	1	14	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Herman Fletcher
13. Birthplace Md

MOTHER
14. Maiden Name Mary ?
15. Birthplace Md

16 (a) Informant John H. Clemmons
(b) Address 1217 W Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-25-47 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Md

18 (a) Funeral director George E. Nelson
(b) Address 1303 Eastman St

19 (a) MAR 25 1947 (Date rec'd by Registrar) (b) Huntington, West Virginia Residence, W.Va.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1947, at 3:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/22 1947 to 3/21 1947 and that I last saw h.e. alive on 3/21 1947

Immediate cause of death	Duration
Myocardial Degeneration	
Due to	
Due to	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas Collins M. D.
Address 1543 Reno Ave Date signed 3/31/47

X

G49974

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G49974

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2530 Calverton Hghts. Ave
(c) Hospital or institution:
16-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2530 Calverton Hghts. Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Glenn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Chas. R. Glenn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1883

8. AGE: Years 63 | Months 4 | Days 19 | If less than one day ....hr. ....min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation H.W.

11. Industry or business

FATHER
12. Name Chas. Friess
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace Germany

16 (a) Informant Chas. R. Glenn Jr.
(b) Address 2530 Calverton Hghts. Ave

17 (a) Burial (b) Date thereof 3/25/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Pk.
Location 3801 Frederick Rd.

18 (a) Funeral director Harry K. Whitaker
Address 4107 Edmondson Ave
MAR 25 1947

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

V S 130

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/22/47 19.... at 7 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/10 1942 to 3/22 1947 and that I last saw h[er] alive on 3/22 1947

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to Chronic Gall Bladder	5 yr
Due to Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph R. Lauckner M. D.
Address 679 Washington Blvd Date signed 3/22/47

G42975

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √61

Registered No. G42975

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1712 Cole St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles A Hands

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-10-9543

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband~~ or wife Margaret M (Tate)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1884

8. AGE: Years	Months	Days	If less than one day
62	8	1718	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Truck Foreman
11. Industry or business Bethlehem Steel Corp

FATHER
12. Name Dexter L Hands
13. Birthplace Md

MOTHER
14. Maiden Name Martha De Graf
15. Birthplace Md

16 (a) Informant Mrs. Margaret Hands
(b) Address 1712 Cole ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 25, 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location 3801 Frederick Rd

18 (a) Funeral director Harry A Gelston
(b) Address 4101 Edmondson Ave

19 (a) MAR 25 1947 (Date received by Registrar) (b) Huntington Hilton Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-22- 1947, at 5:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-21- 1947 to 3-22- 1947 and that I last saw ~~him~~ her alive on 3-22- 1947

Immediate cause of death Coronary Thrombosis - Due to accident Sprain Ankle and Contusion Lumbosacral Region

Duration

Due to Hypertension & Arteriosclerosis.

Due to

Other Conditions Diabetes mellitus, mild.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Lowry M. D.
Address University Hosp Date signed 3-24-47

F3a

G49976

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 132

G49976 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1122 W. Lafayette Ave
(c) Hospital or institution: Baltimore maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1122 W. Lafayette Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Edward J Waters

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-05-7315

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Colord	married

6 (b) Name of husband or wife Lelia C. Waters
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 6 1880

8. AGE: Years	Months	Days	If less than one day
67	1	17	hr. min.

9. Birthplace maryland (town, county, and state)
10. Usual Occupation Labor
11. Industry or business

FATHER 12. Name Edward D Waters
FATHER 13. Birthplace maryland
MOTHER 14. Maiden Name Martha Tilghman
MOTHER 15. Birthplace maryland

16 (a) Informant Lelia C Waters
(b) Address 1122 W. Lafayette ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 (month) 27 (day) 47 (year)
(c) Cemetery or crematory Eutunial Cemetery
Location Somerset County, Md

18 (a) Funeral director Lattie Grosla
(b) Address 1402 Ashland ave

19 MAR 25 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1947, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/19/47 to 3/22/47 and that I last saw h-m alive on 3/19/47

Immediate cause of death Ruptured Pancreatic pseudocyst

Due to Pancreatitis

Due to " "

Other Conditions Hypertension Congestive Heart Failure

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration (Years, Months, Days, or Hours)

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. D. Barksdale M. D.

Address 536 N. Carey St Date signed 3/27/47

VS 160

G49977

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 479

Registered No. G49977

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 609 S.Rappola St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 609 S.Rappola St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles R.Graham

3 (b) If veteran, name war	3 (c) Social Security Account No. 216-07-5511

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Laura E.Gephardt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct.21 1877

8. AGE: Years	Months	Days	If less than one day
69	5	1	hr. min.

9. Birthplace Ill (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Charles
13. Birthplace Ill

MOTHER
14. Maiden Name not known
15. Birthplace Ill

16 (a) Informant Wife
(b) Address 609 S.Rappola St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/25/47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Ave.

18 (a) Funeral director Clarence F.Hoffmann
(b) Address 1639 Broadway

19 (a) MAR 25 1947 (b) Huntington for Williams, M.D. (Registrar's signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 22 1947, at 5:4 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1946 to Mar 22 1947
and that I last saw him alive on Mar 21 1947

Immediate cause of death Carcinoma lungs — Duration 15 mos?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. V. Clift
Address 5010 Greenleaf Rd Date signed 3-29-47

VS 150

C49978

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C49978

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3130 Howard Park Ave.
(c) Hospital or institution: 28
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ----------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3130 Howard Park Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY EDGAR ECKER

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 212-05-5486

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Georgia Pattison Ecker
6 (c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): May 29 1877

8. AGE: Years 69 | Months 9 | Days 23 | If less than one day: 75 hr. ..... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Retired -- Collector

11. Industry or business: Consol. Gas & Electric Co.

FATHER
12. Name: Harry E. Ecker
13. Birthplace: Carroll Co., Md.

MOTHER
14. Maiden Name: Isabelle Barnes
15. Birthplace: Carroll Co., Md.

16 (a) Informant: Raymond Pattison Ecker
(b) Address: 2409 Everton Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Mar. 25 1947 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cemetery
Location: Baltimore, Md.

18 (a) Funeral director: Miller Lamonaco
(b) Address: 2010 Liberty Heights Ave.

19 (a) [illegible] (b) [illegible] Registrar
(Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March, 23 1947 at 10.45 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 15, 1947 to Mar. 23, 1947, and that I last saw him alive on Mar. 22, 1947.

Immediate cause of death	Duration
Coronary Thrombosis	7 days.
Due to Hypertension & Arteriosclerosis	?
Due to	
Other Conditions ---	

(Include pregnancy within 3 months of death)
Date of operation ------
Major findings of operation: ----
of autopsy: -----

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide -----
(b) Date of occurrence ------ at ..... M
(c) Where did injury occur? ------- (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ---- While at work? ----
(Specify type of place)
(e) Means of injury -----

23. Signature: Harry Decker M. D.
Address 2220 Garrison Blvd. Date signed 3/24/47

X

G49979

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G49979 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 807 N. Bentalou St.
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 807 N. Bentalou St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cora Florence Daugherty

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife S. Frederick Daugherty
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 23, 1869

8. AGE: Years	Months	Days	If less than one day
77	6 5	-	hr. min.

9. Birthplace Crisfield, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Custis H. Horsey
13. Birthplace Crisfield, Md.

MOTHER
14. Maiden Name Sarah E. Wilson
15. Birthplace Crisfield, Md.

16 (a) Informant Mr. Desmond H. Daugherty
(b) Address 22 Linden Terrace, Towson, Md.

17 (a) Burial (b) Date thereof Mar. 26, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director Miller & Donovan
(b) Address 4510 Liberty Heights Ave.

MAR 25 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1947, at 11.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 12 1947 to March 3 1947 and that I last saw h. or alive on March 3 1947.

Immediate cause of death	Duration
Coronary Thrombosis	½ hour
Due to Chronic Myocarditis	5 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arthur J. Davies, M. D.
Address 2505 Roslyn Ave. Date signed 3-24-47

G19930 Keek

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

Registered No. G19930

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 800 S Broadway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 - 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 800 S Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Juhan Keek

3 (b) If veteran, name war
3 (c) Social Security Account No. 217-14-2356

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 6 1891

8. AGE: Years	Months	Days	If less than one day
56	2 -	16 -	hr. min.

9. Birthplace Ethiopia (Town, county, and state)
10. Usual Occupation Lawyer
11. Industry or business

FATHER
12. Name No Record
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 26/47 (month) (day) (year)
(c) Cemetery or crematory Forest Hunt of Mary
Location Baltimore

18 (a) Funeral director Fred W. Ozazewski
(b) Address 1930 Eastern Ave

19 MAR 25 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1947, at 10 05 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 16 1947 to March 16 1947. and that I last saw him alive on March 16 1947.

Immediate cause of death: Valvular Heart Disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Silverstein M. D.
Address 22 E. Broadway Date signed 3/24/47

VS 150

G19981

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G19981

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1112 S. East Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 d
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1112 S. East Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Jozefa (Josephine) Wojciechowski

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-07-8129

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widow

6 (b) Name of husband or wife Michael

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17 1890

8. AGE: Years	Months	Days	If less than one day
57	-	6	hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Canning

11. Industry or business McGraff

FATHER
12. Name Graff
13. Birthplace Poland

MOTHER
14. Maiden Name Mrs. Klich
15. Birthplace Poland

16 (a) Informant Szymon Wojciechowski
(b) Address 1112 S. East St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 24/47 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus Cem.
Location Dundalk Ave

18 (a) Funeral director Stephen Sulkowski Inc
(b) Address 1000 S. Kenwood Ave

19 (a) MAR 25 1947 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1947, at 1100 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/3 1947 to 3/23 1947 and that I last saw her alive on 3/23 1947

Immediate cause of death Cerebral Hemmorhage — Duration 20 days

Due to Hypertension Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ethel F. Thurston M. D.

Address 1016 S. East Ave Date signed

VS 150

X 3/24/47

G49932

BALTIMORE CITY HEALTH DEPARTMENT

AB- 109118

CERTIFICATE OF DEATH 1310

G49932 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PREPARE FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 5-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 347 Forrest Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Lillie Mae Pitts

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: Female

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Arthur (D

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1- 1894

8. AGE: Years 53 | Months 0 | Days 20 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Gus Cooper (D
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth (D
15. Birthplace Virginia

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/26/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O Wilson
(b) Address 1000 Edmondson Ave

19 (a) MAR 25 1947 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21- 1947, at 1.35A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-13 1947 to 3-21 1947 and that I last saw her alive on 3-21- 1947

Immediate cause of death: Respiratory Failure — Duration: 1 day

Due to Anaemia - — 1 wk.

Due to Nephrosclerosis - — 7

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy arteriosclerosis, gen and renal arteriolosclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Elmina Beachamp M.D.

Address Balto City Hosp Date signed 3-26-47

VS 150

X

G49983

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G49983
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 108 S. Bouldin St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 108 S. Bouldin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph P. Cunningham

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Carrie P Cunningham

6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) July 8, 1879

8. AGE: Years 79 | Months 8 | Days 15 | If less than one day hr. min. 18 57

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Pattern Maker.

11. Industry or business —

FATHER 12. Name Patrick J. Cunningham

13. Birthplace Ireland

MOTHER 14. Maiden Name Mary

15. Birthplace Ireland

16 (a) Informant Mrs. Wanetta Lowe

(b) Address 108 S. Bouldin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 26, 1947 (month) (day) (year)

(c) Cemetery or crematory Mt. Cathedral

Location Frederick Road

18 (a) Funeral director L. Walter Mayo

(b) Address 619 N. Bouldin St.

MAR 25 1947 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23, 1947, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/21 1947 to 3/23 1947 and that I last saw h[illegible] alive on 3/22 1947

Immediate cause of death
Cerebral Hemorrhage C.V. Disease

Due to Senility

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.

Address 3400 E. Baltimore Date signed 3/25/47

G49984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G49984

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 920 E. Eager St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 920 E. Eager St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Curry

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife: Edward Curry
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1869

8. AGE: Years	Months	Days	If less than one day
77	4	1	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Patrick Wallace
13. Birthplace Ireland

MOTHER
14. Maiden Name Not Known
15. Birthplace Ireland

16 (a) Informant Mrs. Elizabeth Roach
(b) Address 920 E. Eager St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 27/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Cathedral
Location 4300 Old Frederick Rd.

18 (a) Funeral director Edward W. Franklin & Son
(b) Address 922 E. Eager St.

19 (a) MAR 25 1947 (Date rec'd by registrar) (b) Martin F. Willi Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 23, 1947 at 10:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/20 1947 to 3/22 1947 and that I last saw h. alive on 3/22 1947

Immediate cause of death — Duration

Acute Cardiac Failure (Substantive) —
Due to Ch. Myocarditis —
Due to Ch. Hypertension —
Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature A. L. Hornstein M. D.
Address 733 Argyle Ave Date signed 3/25/47

X

C19935

511358

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

Registered No. C19935

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 80 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 854 Abbott Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cora Steinmgell (Steinemagle)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. ✓

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-20-1867

8. AGE: Years 80 | Months 1 | Days 3 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John Sanderlant
13. Birthplace Md

MOTHER 14. Maiden Name Mary Mariana
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-24-47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern ave. Balto Co.

18 (a) Funeral director Elmer H Coppie & Son
(b) Address 924 E. Eager St.

19 (a) MAR 25 1947 (Date received by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 23 1947 at 9 05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 9 1947 to Mar 23 1947 and that I last saw h er alive on Mar 23 1947

Immediate cause of death Pneumonia, Hypostatic — Duration

Due to Syphilis, Cholecystectomy

Due to

Other Conditions Uremia, Mild, — 48 hrs

(Include pregnancy within 3 months of death)
Date of operation 18 March 47
Major findings of operation: Cholecystitis & cholelithiasis, acute
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 3/24/47

VS 190

C49986

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33a

Registered No. C49986

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1063 Harford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1063 Harford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James C. Callahan

3 (b) If veteran, name war None
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Anna M. Kreiger Callahan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15, 1866

8. AGE: Years 80 | Months 11 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business Homewood

FATHER 12. Name Michael Callahan
13. Birthplace Not Known

MOTHER 14. Maiden Name Mary McQuade
15. Birthplace Ireland

16 (a) Informant Mrs. Anna M. Callahan
(b) Address 1063 Harford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 27/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location 4430 Belair Rd.

18 (a) Funeral director Edmund W. Coulbourn & Son
(b) Address 924 E. Eager St.

19 (a) [illegible] (b) Huntington Mills Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 23, 1947 at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 17 1947 to March 23 1947 and that I last saw h[illegible] alive on March 23 1947

Immediate cause of death	Duration
Influenza and Lobar Pneumonia	6 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Eisenberg M. D.
Address 1151 North Ave Date signed 3/24/47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G43987

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4506 Sorrento Road.
(c) Hospital or institution: Colonial Nursing & Convalescent Home.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 125 S. Culver St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William L. Cox.

3 (b) If veteran, name war: none.

3 (c) Social Security Account No. 078-05-1120.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Nora F. Cox.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 15-1870

8. AGE: Years 76 | Months 3 | Days 7 | If less than one day hr. min.

9. Birthplace Essex Co. Va.
(Town, county, and state)

10. Usual Occupation Ship Smith.

11. Industry or business M. & M. Steamship Co.

FATHER
12. Name William Cox.
13. Birthplace Va.

MOTHER
14. Maiden Name Emily Cox.
15. Birthplace Va.

16 (a) Informant Mrs. Nora F. Cox.
(b) Address 125 S. Culver St.

17 (a) Burial. (b) Date thereof March 26/47.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park Cem.
Location Baltimore, Md.

18 (a) Funeral director Charles J. Schwab.
(b) Address 3512 Frederick Ave.

MAR 25 1947 Huntington Williams Jr.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23rd 1947, at 8.15 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 26 1946 to 3-23-1947 and that I last saw him alive on March 18 1947

Immediate cause of death	Duration
Myocarditis —	
(a) Arterio — Sclerotic	½-1 yr.
Due to Cerebral Apoplexy	7 yrs.
Due to (a) Hemiplegia	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. Lloyd Inman M. D.
Address Catonsville Md. Date signed 3/24/47

VS 150

G49988

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 63B

G49988 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calhoun & Fayette
(c) Hospital or institution: Franklin Square Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Maryland (If outside city or town limits, write RURAL and give town)
(d) Street No. 401 N Carey St (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) **FULL NAME** Margaret Montague

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife Irwin Montague
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 2, 1911

8. AGE: Years	Months	Days	If less than one day
36	0	22	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Day's Work.
11. Industry or business

FATHER
12. Name John Stinson
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Crusting
15. Birthplace Md.

16 (a) Informant Irwin Montague
(b) Address 401 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-24-47 (month) (day) (year)
(c) Cemetery or crematory Salem
Location Glen Burnie, Md.

18 (a) Funeral director Geo. L. Lord
(b) Address Baltimore, Md.

19 (a) MAR 25 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-24-47 1947 at 3:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-28 1947 to 3-24 1947 and that I last saw him alive on 3-24 1947

Immediate cause of death	Duration
Cardiac decompensation	2 wks.
Due to Thyrotoxicosis	3 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stanley B. Myanowe M.D.
Address Franklin Square Hosp. Date signed 3-24-47

VS 150

G49989

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √181

G49989 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully examined. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3206 Gibbons Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard John Maygers - Sr.

3 (b) If veteran, name war –

3 (c) Social Security Account No. –

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Marguerite E.
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 17-1899

8. AGE: Years	Months	Days	If less than one day
47	11	247	hr. min.

9. Birthplace Balto - Md.
(Town, county, and state)

10. Usual Occupation Chief Operator
11. Industry or business Standard Oil Co.

FATHER
12. Name Charles A. Maygers
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine Hoffman
15. Birthplace Md.

16 (a) Informant Mrs. Marguerite Maygers
(b) Address 3206 Gibbons Ave.

17 (a) Burial (b) Date thereof 3/27/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto.

18 (a) Funeral director Leonard J. Reck
(b) Address 5305 Harford Road

19 (a) MAR 25 1947 [illegible] Williams Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-24-1947, at 12 45 AM

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Shock

Due to 1st - 2nd degree burns involving 90 % of body Surface

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 26/6
(a) Date of injury 3-23-47 at 5:45 P. M.
(b) Where did injury occur Standard Oil Co. Boston-Hanover Sts
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial. While at work? Yes
(d) Means of injury Explosion in gas compressor room

23. Signature Thomas J. Williams M.D.
Medical Examiner.
Date signed 3-24-47

VS 181

G49990

Dr. Todd
2108 St. Paul St.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 50

Registered No. G49990

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5109 Walther Blvd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5109 Walther Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Fay Knepper Llewelyn

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife William J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25, 1884

8. AGE: Years	Months	Days	If less than one day
63	1	26	19 hr. min.

9. Birthplace Newport, Kentucky (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name William Knepper
13. Birthplace Ky

MOTHER
14. Maiden Name Elizabeth Clary
15. Birthplace Ky

16 (a) Informant Mrs. William J. Llewelyn
(b) Address 5109 Walther Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/26/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) MAR 25 1947 (Date rec'd by registrar) (b) Huntington Hill Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23rd, 1947, at 2.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1943 to Mar 23 1947 and that I last saw h[er] alive on March 22 1947.

Immediate cause of death	Duration
Carcinoma of breast,	
Due to Lungs + oesophagus	4 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Homer L. Todd M.D.
Address 2108 St Paul St Date signed 3/24/47

V S 150

X

G49991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

467

Registered No. G49991

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 45 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Minn. (b) County
(c) City or town Duluth
(If outside city or town limits, write RURAL and give town)
(d) Street No. 609 W. Superior St.
(If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Canada

3 (a) FULL NAME Culbertson, Robert Bolton

3 (b) If veteran, name war	3 (c) Social Security Account No. 473-05-6185

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 24, 1880

8. AGE: Years	Months	Days	If less than one day
66	11	21	24 hr. min.

9. Birthplace ? Canada (Town, county, and state)
10. Usual Occupation Messman
11. Industry or business Seafarer

FATHER
12. Name Thomas Culbertson
13. Birthplace ?

MOTHER
14. Maiden Name Alice Combs
15. Birthplace ?

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/25/47 (month) (day) (year)
(c) Cemetery or crematory Forest Dale Cemetery
Location York Road

18 (a) Funeral director Odell Funeral Home Inc.
(b) Address 4027 25th St.

19 MAR 25 1947 (Date rec'd by registrar) (b) Hunting for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 17 1947, at 6:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 31 1947 to Mar. 17 1947, and that I last saw him alive on Mar. 17 1947.

	Duration
Immediate cause of death (1) Papillary carcinoma of rectum with extension to pelvis	UNKNOWN
Due to (2) Pelvic abscess due to above	UNKNOWN
Other conditions: Due to Pyelonephritis, acute bilateral	FEW WEEKS
Other Conditions Bronchopneumonia terminal	ONE WEEK

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M.D.
Address Clinical Director Date signed 3/24/47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G49992

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 518

Registered No. G49992

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1021 Mc=Alees Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1021 Mc=Alees Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Paul

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Emma Paul

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.) Dec 24 1870

8. AGE: Years 76 Months 2 Days 29 If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Jamon Paul

13. Birthplace Mass.

MOTHER 14. Maiden Name Mary ?

15. Birthplace Germany

16 (a) Informant Emma Paul

(b) Address 1021 Mc=Alees Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/25/47 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Easton Md.

18 (a) Funeral director John C Moran

(b) Address 3600 E Baltimore St

19 (a) MAR 25 1947 (Date rec'd by registrar) Registrar for Williams

V S 130

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/22 1947, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1 1947, to 3/22 1947, and that I last saw him alive on 3/22 1947

Immediate cause of death: Carc. Pulmonary Edema — Duration: 2 days

Due to: Carcinoma of the Bladder and Pyelitis Chronic

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature Wright J. Seidler M.D.

Address 3320 E Balto St Date signed 3/23/47

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93c

Registered No. 49993

49993

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 614 Sarah Ann St.
(c) Hospital or institution:
University Hospital 4-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 614 Sarah Ann St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Burton (BURTON.)

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C.	Single

6 (b) Name of husband or wife ~~If married, widowed, or divorced~~
6 (c) If alive, give age 3 years

7. Birth date of deceased (mo., day, yr.) 11-2-1916

8. AGE: Years	Months	Days	If less than one day
30.	4	21	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation House Work
11. Industry or business

FATHER
12. Name Harrison Burton.
13. Birthplace Va.

MOTHER
14. Maiden Name Lillian Barber
15. Birthplace Md

16 (a) Informant Lillian Burton.
(b) Address 614 Sarah Ann St

17 (a) Burial (b) Date thereof 3 26 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director Mulligan & Jackson
(b) Address 916 Pulaski ave

19 (Signature) Huntington Williams M.D.
Registrar's signature
MAR 25 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1947 at 11:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 23 1947 to March 23 19 47
and that I last saw h alive on 19

Immediate cause of death	Duration
Cardiac Failure	
Due to Pneumonia	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Milton Resch M. D.
Address Edwood & Green Sts Date signed 3/24/47

Honors of Medicine M.D.

G49991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G49991 Registered No. 13B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 230 North Pearl
(c) Hospital or institution: 4-

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 230 North Pearl Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MATTIE STOKES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex f | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Linwood

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 7-6-1924

8. AGE: Years 22 | Months 8 | Days 17 | If less than one day ____ hr. ____ min.

9. Birthplace Alabama (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name James Wright
13. Birthplace Ala.

MOTHER
14. Maiden Name Etta Woods
15. Birthplace Tenn.

16 (a) Informant Linwood Stokes
(b) Address 230 N. Pearl st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-27-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna ave

19 (a) MAR 25 1947 (Date received by registrar) (b) Hattie Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/23/47 19 , at 8:00 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Ayers M.D. Medical Examiner.
Date signed

VS 181

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Typewrite or write the causes of death clearly and legibly. correct age is especially important. Physicians: please write

G49995

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 61

Registered No. G49995

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 802 S Kenwood Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 802 S. Kenwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Petty

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Charles Petty
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 19 1879

8. AGE: Years	Months	Days	If less than one day
67	4	4	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name William Brandt
13. Birthplace Germany

MOTHER
14. Maiden Name Ida Ose
15. Birthplace Germany

16 (a) Informant William F Petty
(b) Address 802 S. Kenwood Ave

17 (a) Burial (b) Date thereof 3/26/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location 7200 Eastern Ave

18 (a) Funeral director John J. Duda
(b) Address 2829 Baldwin St

19 MAR 25 1941 (b) Hunter for Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 23 - 1947, at 12 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 20 1946 to Mar 23 1947, and that I last saw h[illegible] alive on Mar 23 - 1947

Immediate cause of death	Duration
Coronary Occlusion Mar 23	1947
Myocarditis	1946
Due to Arteriosclerosis	1946
Diabetes	1946
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature L. J. Hellman M. D.
Address 306 Bond N Date signed 3/26/47

V S 150

X

G49996

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G49996 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 927
(c) Hospital or institution West Baltimore General

(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3119 Harford (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William E Gammie

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Alice Gammie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 16, 1868

8. AGE: Years	Months	Days	If less than one day
79	-	8	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Decorator
11. Industry or business

FATHER
12. Name George Gammie
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Ellen M. Nash
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Donald Gammie
(b) Address 3711 Clifton avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/26/47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Harford road

18 (a) Funeral director Thos. J. Evans Son Inc.
(b) Address 418 N. Mt. Royal Ave

19 (a) MAR 25 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/24/47 19 at 9:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John Reard, M.D. Medical Examiner.
Date signed 3/25/47

VS 131

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49997

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 E

Registered No. G49997

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 603 LENOX STREET.
(c) Hospital or institution: NONE 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) NONE
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY. (If outside city or town limits, write RURAL and give town) 2
(d) Street No. 603 LENOX STREET. (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH KELLY. (JOSEPH J. KELLY)

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4, 1872

8. AGE: Years	Months	Days	If less than one day
74	11	19	hr. min.

9. Birthplace Mt. Washington, Balto. Md. (Town, county, and state)
10. Usual Occupation Carriage Builder
11. Industry or business Retired

FATHER
12. Name Simon Kelly
13. Birthplace Ireland

MOTHER
14. Maiden Name Anastatia Cahill
15. Birthplace Ireland

16 (a) Informant Miss Mary Kelly
(b) Address 603 Lennox street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/26/47 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Govans

18 (a) Funeral director Chas. P. Evans Son Inc
(b) Address 118 N. Mt. Royal Ave

19 (a) MAR 25 46 (Date received by Registrar) (b) Huntingdon Millington Md (Registrar)

MEDICAL CERTIFICATION A

20. DATE OF DEATH MARCH 23 1947 at 11.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from AUG.20 1946 to MARCH.23 1947 and that I last saw h Im alive on MAR 23 1947.

Immediate cause of death	Duration
CARCINOMIA SIGMOID FLEXURE	AUG 20.4
Due to CHRONIC MYOCARDITIS	1946.
Due to ARTERIOR SCLEROSIS	1946
Other Conditions NONE (Include pregnancy within 3 months of death)	
Date of operation NONE	
Major findings of operation: NONE	
of autopsy: NO.	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify kind of place)
(e) Means of injury

23. Signature Theo P. Clemente M. D.
Address 3013 ST PAUL STREET. Date signed MAR.23

VS 150

G49998 BC# 71299 ✓107

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G49998

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1736 Westfall Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1736 Westfall Place (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William L. Geisler

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife ----
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1947

8. AGE: Years	Months	Days	If less than one day
	1	10	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Thomas F. Geisler
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Katherine M. Crispen
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Thomas F. Geisler
(b) Address 1736 Westphal Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location

18 (a) Funeral director Chas. D. Evans Son, Inc.
(b) Address 114 N. Mt. Royal Ave.

19 (a) MAR 25 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1947, at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bronchopneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil H. Regan M.D. Medical Examiner.
Date signed 3-24-47

X

G49999

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

G49999 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 9-D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1915 Homewood Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine P. Sullivan

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 28, 1868

8. AGE: Years 78 | Months 2 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Joseph P. Pate
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Catherine Mooney
15. Birthplace Baltimore, Maryland

16 (a) Informant Mr. Harry P. Feihe
(b) Address 1915 Homewood avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/47 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location

18 (a) Funeral director Chas. J. Evans Son Inc
(b) Address 118 N. Mt. Royal Ave.

19 (a) MAR 25 1947 (Date received by local registrar) Penelope for William [illegible]

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24, 1947, at 9.10 A M

21. I certify that I took charge of the remains described above, held an ____ thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio - Vascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Weddis M.D.
Medical Examiner.
Date signed 3-24-47

50000

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. 50000

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution: Church Home & Hospital 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 50 E Heath St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Margaret Reichert

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ Deceased

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 22 1880

8. AGE: Years	Months	Days	If less than one day
67	0	1	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business Home

FATHER
12. Name August Kern
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Lena Diehl
15. Birthplace Baltimore Md

16 (a) Informant Mrs Margaret Lehrman
(b) Address 3112 Cedarhurst Rd.

17 (a) Burial (b) Date thereof 3/26/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Parkwood
Location

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4814 Park Heights Ave

19 (a) MAR 25 1947 (b) Huntington Williams Md
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-23 1947, at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-15- 1947 to 3-23 1947 and that I last saw her alive on 3-23- 1947

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to Carcinomatosis	
Due to	1 year
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 3-6-47
Major findings of operation: Carcinomatosis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature John A. Ravin M. D.
Address Church Home & Hosp. Date signed

VS 190

X

G-0001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8312

G-0001

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lee & Lombard Sts.
(c) Hospital or institution University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Union Bridge
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert G. ENGLAR

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex male | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Maria S. Englar
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 2 - 1881

8. AGE: Years 65 | Months 7 8 | Days 24 | If less than one day hr. min.

9. Birthplace Carroll County, Md.
(Town, county, or state)

10. Usual Occupation Retired Farmer

11. Industry or business

FATHER
12. Name Alfred Englar
13. Birthplace Maryland

MOTHER
14. Maiden Name Eliza Koons
15. Birthplace Maryland

16 (a) Informant Edwin Englar
(b) Address Mayo Windsor, Md.

17 (a) Burial (b) Date thereof Mar 29-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Pipe Creek Cem.
Location Uniontown Road

18 (a) Funeral director H. H. Stanton & Sons
(b) Address Budget Mode Westminster, Md.

19 MAR 26 1947 (Signature) Hunter for Williams M.D.
(Date rec'd by Registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-26- 1947, at 2 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-25- 1947 to 3-26- 1947. and that I last saw him alive on 3-26- 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Cerebral Thrombosis	
Due to Generalized arteriosclerosis	
Other Conditions Ac. Uremia Recent Prostatic Hypertrophy	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H Parry M. D.
Address Univ. Hosp. Date signed 3-26-47

G50003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

G50003 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 316 E 26th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 316 E 26th St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marvin Lee Knight

3 (b) If veteran, name war
3 (c) Social Security Account No. none

4. Color or race: ~~White~~ Negro
5. Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Sarah E
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16 1873

8. AGE: Years 73 | Months 7 | Days 8 | If less than one day: hr. min.

9. Birthplace Howard Co Md (Town, county, and state)
10. Usual Occupation Mechanical Cabinet
11. Industry or business Ga R.R.

FATHER
12. Name John T. Knight
13. Birthplace Md

MOTHER
14. Maiden Name Mary Jane Gourley
15. Birthplace Md

16 (a) Informant Mrs John T. Knight
(b) Address 316 E 26th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/47 (month) (day) (year)
(c) Cemetery or crematory St Marys
Location Baltimore Md

18 (a) Funeral director Wilson & Son
(b) Address 1217 Park Ave

19 MAR 26 1947 (Date received by local registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1947 at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 14 1946 to March 24 1947 and that I last saw h alive on 19

Immediate cause of death	Duration
Carcinoma of Stomach	5 Mo
Due to Senile Degeneration	1 Yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Horace H Rogers M. D.
Address 248 Mansfield Ave Date signed March 25 47

abe X

G50003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

G50003 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1026 Brentwood ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Minnicks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: ?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 7, 1903

8. AGE: Years 43 | Months 7 | Days 17 | If less than one day: hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name George Minnicks
13. Birthplace Maryland

MOTHER 14. Maiden Name Todd ?
15. Birthplace Maryland

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 3/27/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Balto. Md

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) [illegible] (b) [illegible] for Williams MD

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1947, at 3:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 21 1947 to March 24 1947, and that I last saw him alive on March 21 1947.

Immediate cause of death	Duration
SEVERE DIABETIC COMA (DIED FIRST HOUR IN HOSPITAL)	24 Hrs.
Due to DIABETES MELLITUS	4 yrs.
Due to	
Other Conditions Rheumatic HEART DISEASE INACTIVE (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
Bl. Sugar 1400, CO_2 5.6	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maxwell Williams M. D.
Address Johns Hopkins Hospital Date signed 3-25-47

VS 180

X

C-0001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. C-0001

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) C

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town East Moline (If outside city or town limits, write RURAL and give town)
(d) Street No. 135 E 16th St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Irene DePaepe

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-27-43

8. AGE: Years 3 | Months 8 | Days 28 | If less than one day hr. min.

9. Birthplace Illinois (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER — 12. Name John DePaepe
13. Birthplace Belgium

MOTHER — 14. Maiden Name Rosa Siberman
15. Birthplace Illinois

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory East Moline
Location East Moline Ill.

18 (a) Funeral director John O Mitchell & Sons
(b) Address 1500 Eutaw Place

19 Mar 26 1947 (By whom) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 19 47, at 5:16 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/20/47 19 , to 3/25/47 19 , and that I last saw h alive on 3/25/47 19

Immediate cause of death Congenital Heart disease — Duration Life

Due to

Due to

Other Conditions Tetralogy of Fallot (Include pregnancy within 3 months of death)

Date of operation 3/24/47

Major findings of operation: Pulmonic stenosis

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Henry T. Bahnson
Address Johns Hopkins Hospital Date signed 3/25/47

G-0005

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1131a

Registered No. G-0005

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1 W. Lee St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1 W. Lee St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE LAURIE PARKS

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband ~~or wife~~: Isaac H. Parks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 2, 1870

8. AGE: Years	Months	Days	If less than one day
76	10	21	hr. min.

9. Birthplace: Prince George Co. Md. (Town, county, and state)
10. Usual Occupation: None
11. Industry or business:

FATHER
12. Name: John Nothey
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Nothey
15. Birthplace: Unknown

16 (a) Informant: Mrs. L. Tyskiewicz, Daughter
(b) Address: 2677 Eagle St. 23

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/26/47 (month) (day) (year)
(c) Cemetery ~~xxxxxxxx~~ Mt. Olivet Cem.
Location: Baltimore, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS INC.
(b) Address: North & Pa. Aves. Balto. 17, Md

19 (a) 3-26-1947 (Date rec'd by Registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 23, 1947, at 12:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 Mar 1947 to 23 Mar 1947.
and that I last saw her alive on 23 Mar 1947.

Immediate cause of death	Duration
Bronchopneumonia	48 hrs.
Pulmonary edema	48 hrs.
Due to Cerebral Hemorrhage	96 hrs
Due to Hypertensive C-V-R Disease, Arteriosclerosis	
Other Conditions Senility	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herman H. Bayliss M. D.
Address 600 Wilkens Ave. Date signed 25 Mar 47

VS 150

G 50006

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1947

Registered No. G 50006

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2022 Clifton Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2022 Clifton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Osterman JOHN JOSEPH OSTERMANN JR.

3 (b) If veteran, name war: World I

3 (c) Social Security Account No.: Yes

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Henrietta A. Ostermann

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept. 7, 1894

8. AGE: Years: 52 | Months: 6 | Days: 16 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: U. S. Gov't Clerk

11. Industry or business: Edgewood Arsenal

FATHER
12. Name: John Ostermann
13. Birthplace: Balto. Md.

MOTHER
14. Maiden Name: Catherine Bauerfiend
15. Birthplace: Balto., Md.

16 (a) Informant: Mrs. Henrietta A. Ostermann
(b) Address: 2022 Clifton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/47 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Balto. Nat'l Cem.
Location: Baltimore Md.

18 (a) Funeral director: WM. J. TICKNER & SONS INC.
(b) Address: North & Pa. Aves. Balto. 17, Md

19 (a) MAR 26 1947 (Date received by registrar) Huntington Williams M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/23 1947, at 12 Noon M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the cause of death were

IMMEDIATE CAUSE OF DEATH: Coronary Vascular Disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John L. Evans M.D. Medical Examiner.
Date signed 3/26/47

G5007 F

Birth Certificate # 74462

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160c

Registered No. G5007

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County –
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3120 St. Paul St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Norton
BABY ANNINA NORTON

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: F
5. Color or race: White
6 (a) Single, married, widowed, or divorced: –
6 (b) Name of husband or wife: –
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 23 March 1947
8. AGE: Years 0 Months 0 Days 2 If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation –
11. Industry or business –

FATHER
12. Name Richard Edward Norton
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mildred Elizabeth Byrnes
15. Birthplace Balt. Md.

16 (a) Informant Mr. C. P. Byrne,
(b) Address 3120 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/26/47 (month) (day) (year)
(c) Cemetery New Cathedral Cem.
Location Balto. Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa Aves. Balto. 17, Md.

19 (a) MAR 26 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 March 1947, at 5-40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 23 March 1947 to 25 March 1947, and that I last saw her alive on 25 March 1947.

Immediate cause of death	Duration
Atelectasis bilat. lungs	
Due to Cord around neck during labor	
Due to	
Other Conditions Congenital heart?	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Malcolm J. Hurst M. D.
Address Union Mem. Hosp. Date signed 3-27-47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C50008

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47e

C50008 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Colored Sanatoga
(c) Hospital or institution: Mercy. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt
(c) City or town Balt - 16 (If outside city or town limits, write RURAL and give town)
(d) Street No. 2704 Pinkney St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Hatter. CHARLES H. HATTER

3 (b) If veteran, name war: None

3 (c) Social Security Account No.? 213-10-0650

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Dorthey Hatter.

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 5-26-1878

8. AGE: Years 68 | Months 10 | Days 29 | If less than one day ____ hr. ____ min.

9. Birthplace Reisterstown Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Balt. Transit Co

FATHER 12. Name Nicholas Hatter

FATHER 13. Birthplace Germany

MOTHER 14. Maiden Name Elis Kirby

MOTHER 15. Birthplace Balt. Md.

16 (a) Informant Dorthey Hatter

(b) Address 2704 Pinkney St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/47 (month) (day) (year)

(c) Cemetery or ~~Crematory~~ All Saints

Location Reisterstown, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.

(b) Address North & Pa. Aves. Balto. 17, Md.

19 MAR 26 1947 (Date rec'd by registrar) Hunting for Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-25 1947, at 7:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-3 1947 to 3-25 1947. and that I last saw h/m alive on 3-25 1947

Immediate cause of death	Duration
Resp failure	
Due to Cerebral Hemorrhage	
Due to Bronchopneumonia	
Other Conditions Chronic Glomerulo nephritis (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr Rothery

Address Colored Sanatoga Date signed 3/26/47 M. D.

VS 150.

G50009 Butler Certificate G-78854

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 158

Registered No. G50009

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2025 W. Fayette St.

(c) Hospital or institution: Bon Secours Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1Day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore - 16 (If outside city or town limits, write RURAL and give town)

(d) Street No. 1532 N. Smallwood St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Boy Simmons. Lewis Tyler Simmons Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-23-47

8. AGE: Years	Months	Days	If less than one day
		1	min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Louis Tyler Simmons

13. Birthplace Baltimore Maryland

MOTHER

14. Maiden Name Emma Margaret Linsenmeyer

15. Birthplace Baltimore Maryland

16 (a) Informant Hospital Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/26/47 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore, Md

18 (a) Funeral director William J. Tickner & Sons

(b) Address North & Pennsylvania Aves

19 (a) MAR 26 1947 (Date received by local registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION 10:30 P.

20. DATE OF DEATH 3-24-1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 23 1947 to March 24 1947, and that I last saw him alive on March 24 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Central nervous	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Huntington Williams M. D.

Address 13 W. Lanvale St. Date signed 3-24-47

X

G50030
AB-12178

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

108

G50010
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 74
(d) Length of stay in hospital or inst. 11yrs. 2mos. 4days
(e) Length of stay in Baltimore (yrs., mos., or days) 52yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1102 Fort Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Trost

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 11- 1863

8. AGE: Years	Months	Days	If less than one day
84	1	8	hr. min.

9. Birthplace Austria
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Frank Trost
13. Birthplace Austria

MOTHER
14. Maiden Name Marie Desmond
15. Birthplace Austria

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 3/20/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Bonnie Shiel Rd

18 (a) Funeral director Gahey Bros
(b) Address 131 E. Eight St.

19 (a) MAR 26 1947 (b) Clayton Williams M.D.
Date received by registrar Local registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19- 1947, at 7.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-15- 1935, to 3-19 1947, and that I last saw h in alive on 3-19 1947

Immediate cause of death	Duration
Pneumonia lobar	
Due to Hypertensive cardiovascular disease	
Due to Arteriosclerosis, generalized	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. Powell Hoffmann M. D.
Address Baltimore City Hosp. Date signed 24 Mar 47

X

G50011

AB-77590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G50011

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26-12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4yrs-4mos.-26days
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. No Home (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter J. Sloper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Divorced

6 (b) Name of husband or wife Jennie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 5, 1863

8. AGE: Years	Months	Days	If less than one day
83	6	15	hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Samuel J. Sloper
13. Birthplace Ireland

MOTHER
14. Maiden Name Nellie Vaughn
15. Birthplace New York

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/26/47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Gunpowder Hill Rd

18 (a) Funeral director [illegible]
(b) Address 131 Biddle St.

19 (a) MAR 26 1947 (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1947, at 8.45P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-24 1942 to 3-20 1947, and that I last saw h im alive on 3-20 1947.

Immediate cause of death Hypertensive C.V. Disease

Due to Generalized Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. Russell Hoffmann M. D.
Address Baltimore City Hosp Date signed 3-26-47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50012

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

G50012 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 838 Hampson Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLINTON HALL

3 (b) If veteran, name war	3 (c) Social Security Account No.
W.W 2	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	married

6 (b) Name of husband or wife. Ethel Hall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 15, 1920

8. AGE: Years	Months	Days	If less than one day
26	3	8	hr. min.

9. Birthplace Wilson n. c.
(Town, county, and state)
10. Usual Occupation chauffeur
11. Industry or business

FATHER
12. Name Frank Hall
13. Birthplace n. c

MOTHER
14. Maiden Name Elizabeth Higgins
15. Birthplace n. c.

16 (a) Informant Arthur Hall
(b) Address 848 Hampsm St

17 (a) Burial (b) Date thereof 3-27-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto nat
Location md

18 (a) Funeral director George D. Wilson
(b) Address 1303 Presstman St

19 (a) (b)
(Date rec'd by Registrar) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23, 1947, at 7.30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet- wound of brain
Bullet- wounds of right lungs

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-23-47 at 6.45 p. M.
(b) Where did injury occur? 838 Hampson St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearms

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 3-24-47

G50013

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G50013

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 3520 N. Hilton Rd.
(b) Street address 3204 Ethelbert Ave.
(c) Hospital or institution: Ashburton House - Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yr. 10 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3204 Ethelbert Ave.
(If rural give location)
(e) Citizen of foreign country? 5 (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Eschleman Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Married

6 (b) Name of husband or wife Charles A. Brown
6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) Apr. 21, 1889

8. AGE: Years	Months	Days	If less than one day, hr.	min.
67	11	4		1879

9. Birthplace Pa - Lancaster Co.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Benj. Eschleman
13. Birthplace Pa

MOTHER
14. Maiden Name Lydia Miller
15. Birthplace Pa

16 (a) Informant Mrs. Geo. G. Brown
(b) Address 5204 Ethelbert Ave. Balt. Md

17 (a) Burial (b) Date thereof Mar. 29-1937
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Burial Ground
Location Peach Bottom, Lancaster Co. Pa.

18 (a) Funeral director Fredric L. Cauffman
(b) Address Peach Bottom, Pa.

19 (a) MAR 26 1937 (b)
(Date rec'd by registrar) Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1937, at 12 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 21 1936, to March 25 1937, and that I last saw her alive on March 25 1937.

Immediate cause of death: Bronchial pneumonia — Duration: 2 days
Due to:
Due to:
Other Conditions: Cerebral Arteriosclerosis Hypertensive Cardio Vasc. Dis. — 10 yrs.
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Weston E. Lamman M. D.
Address 4643 Park Heights Ave. Date signed 3-26-37

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G50011

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G50014

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 112 S. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Goedeke

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: none

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Harry H. Goedeke

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): August 28, 1893

8. AGE: Years 54 | Months 8 | Days 24 | If less than one day: 27 hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: (Housewife) Missionary

11. Industry or business: Church Worker

FATHER
12. Name: Frederick G. Hoener
13. Birthplace: Germany

MOTHER
14. Maiden Name: Katie A. Diering
15. Birthplace: Baltimore, Maryland

16 (a) Informant: Mr. Christopher Diering
(b) Address: 2914 Winchester Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/28/47 (month) (day) (year)
(c) Cemetery or crematory: St. Mathews cem
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE & BROADWAY

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

MAR 26 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/24 1947, at 11:45 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Depressed fracture of skull

Due to:

Other Conditions: Obesity
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/24/47 at about 11:45 P M. 2/2
(b) Where did injury occur? 112 S. Broadway
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury: Fell down outside steps

23. Signature: [illegible] M.D.
Medical Examiner.
Date signed 3/25/47

X

G50015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G50015 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1812 N. Chester Street
(c) Hospital or institution: 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Maryland
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARIE ELEANOR AMOS

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John Edwin Amos

6 (c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): May 7, 1897

8. AGE: Years 49 | Months 10 | Days 16 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Andrew George
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Catherine Schraum
15. Birthplace: Washington, D.C.

16 (a) Informant: Mr. John E. Amos
(b) Address: 1812 N. Chester Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/26/47 (month) (day) (year)
(c) Cemetery or crematory: Parkwood Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 26 1947 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1947, 3.35P M

21. I certify that death occurred on the date above stated; that I attended deceased from February 10 1946 to March 23 1947 and that I last saw h[illegible] alive on March 23 1947

Immediate cause of death	Duration
Carcinoma of ~~Left~~ Breast	13 months
Due to Cachexia and Metastases	2 months
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Mastectomy Feb 1946
Major findings of operation: Carcinoma
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Sidenberg M.D.
Address 1005 E North Ave Date signed 3/24/47

X

G50016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G50016 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4702 HARFORD AVE. 15
(c) Hospital or institution:
CONVALESENCE HOME.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9.MONTH
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2215 WEST NORTH AVE
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MARY.A. LAUTENBACH.

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. NONE

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife: George W. Lautenbach
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 24, 1875

8. AGE: Years 72 | Months 2 | Days 0 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Theodore Heckman
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Sally Larkins
15. Birthplace paltimore, Md.

16 (a) Informant Mr. Joseph E. Burns
(b) Address 2804 Lake Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/47 (month) (day) (year)
(c) Cemetery or crematory PARKWOOD CEMETERY
Location BALTIMORE, MARYLAND

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH MARCH 24 1947 19, at 7.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from JULY 2 1946, to MARCH 24 47 and that I last saw h ER alive on MARCH 24 19 47.

Immediate cause of death	Duration
DIABETES MELLITUS	1943.
Due to CHRONIC ARTHRITIS DEFORNANS	1945.
Due to ARTERIOR SCLEROSIS	1945.
Other Conditions SENILE CHANGES.	

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation: NONE
of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. P. Cloutier, M.D.
Address 3013 ST PAUL STREET Date signed MARCG 24 1947

VS 150

MAR 26 1947

Huntington Williams M.D.

Chas. P. Cloutier
X

G50017

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 935

Registered No. G50017

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2510 Greenmount Ave.
(c) Hospital or institution:
Southern Hospital & Home 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1815 E. 22nd St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME John ~~Emmert~~ Hammar

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 28, 1868

8. AGE: Years	Months	Days	If less than one day
79	--	24	hr. min.

9. Birthplace Elkridge, Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Philip ~~Emmert~~ Hammar
13. Birthplace Md.

MOTHER
14. Maiden Name Marie Magdalena Hasinger
15. Birthplace Md.

16 (a) Informant Records, Southern Home
(b) Address 2510 Greenmount Ave.

17 (a) Burial (b) Date thereof 3/27/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Methodist Church
Location Elkridge, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) MAR 26 1947 (b)
Filed by registrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-20- 1947 to 3-24 1947.
and that I last saw him alive on 3-23- 1947:

Immediate cause of death	Duration
Chronic Myocarditis	1 yr
Due to Arterio Sclerosis	several years
Due to old age	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Shirley C. Blake M. D.
Address Medical Arts Bldg. Date signed 3/26/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164E

Registered No. G50018

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 5/12 1936
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1623 Cypress St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wassil Stasnik

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Known

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace Russian (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name ? Stasnik
13. Birthplace Russian

MOTHER
14. Maiden Name not known
15. Birthplace Russian

16 (a) Informant Alex Skruckuk
(b) Address 5021 Pennington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-26-47 (month) (day) (year)
(c) Cemetery or crematory Holy Trinity Russian
Location Stoney Run, Md

18 (a) Funeral director John A Grebenkewich
(b) Address 423 S. Paca St

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

MAR 26 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/23 1947 at 12 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Neck

Due to

Other Conditions Peripheral Decay

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/23/47 at M.
(b) Where did injury occur? Balto City Hospital
(c) Did injury occur at home, on farm, industrial place, in public place? Hospital While at work? No
(d) Means of injury Jumped from 4th floor window

23. Signature B. F. Sulowski M.D.
Medical Examiner.
Date signed 3/24/47

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C50019 95c ✓ Registered No. C50019

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

C50019

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1625 Edmondson Ave.
(c) Hospital or institution:
19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1625 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LILLIE S. AMES

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife John Ames
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 18, 1890

8. AGE: Years	Months	Days	If less than one day
57	-	5 6	hr. min.

9. Birthplace Harford Co., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Waters
13. Birthplace Harford Co., Md.

MOTHER
14. Maiden Name Harriet Giles
15. Birthplace Harford Co., Md.

16 (a) Informant Mr. John Ames
(b) Address 1625 Edmondson Ave.

17 (a) Burial (b) Date thereof 3-27-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location Mountain, Harford Co., Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (b)
(Date received by Registrar)

MAR 26 1947

Huntington Ave

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH March 24 1947, at 1:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 20 1947 to March 23 1947
and that I last saw h.er alive on March 23 1947

Immediate cause of death Organic Heart Disease — Duration Before Interval

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Garland Churchill M.D.
Address 1524 Druid Hill Ave Date signed Mch 25

X

G50020

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G50020

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 223 Patapsco Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 223 Patapsco ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Emil A. Klingbeil.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11th 1867

8. AGE: Years	Months	Days	If less than one day
79 80	8 9	13	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Retired Merchant

11. Industry or business

FATHER
12. Name C. Klingbeil.
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mr. Chas Gisen
(b) Address 221 Potapsco Ave.

17 (a) Burial (b) Date thereof March 26, 47
(Burial, cremation, or removal) (month) (day), (year)
(c) Cemetery or crematory Glen Haven Memorial Cemetery
Location Glenburnie Md.

18 (a) Funeral director Milton Schilling
(b) Address 3914 Hanover St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 19 MAR 26 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1947, at 12:35 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mendis M.D.
Medical Examiner.
Date signed 3-24-47

G50021

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82

G50021

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 306 Poplelon St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 306 Poplelon St (If rural give location)
(e) Citizen of foreign country? Poplelon (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Johnson.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 1-30-1928

8. AGE: Years 19 | Months 1 | Days 25 26 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Laundress

11. Industry or business

FATHER
12. Name Alvin Johnson.
13. Birthplace Md

MOTHER
14. Maiden Name Florence ?.
15. Birthplace Md

16 (a) Informant Florence Johnson.
(b) Address 306 Poplelon St

17 (a) Burial (b) Date thereof 3 25 47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem
Location Balto. County Md

18 (a) Funeral director Wm A Patterson
(b) Address 916 Penna ave

19 (a) ____ (b) ____
(Date rec'd by registrar) Registrar

VS 150 MAR 26 1947 Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1947, at 2 40 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 17 1947, to March 25 1947 and that I last saw h alive on March 20 Sept

Immediate cause of death
(a) Cerebral Spinal
Due to Lead poisoning, Brain
(b) Due to Infection
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration
3 months

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 708 E. Preap St. Date signed 3/26/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

G5003 BCH 66543 CERTIFICATE OF DEATH 107 Registered No. 04-00282

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital. 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1205 Nolan Court.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Pulley

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 24, 1946

8. AGE: Years	Months	Days	If less than one day
	3	-	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER 12. Name Henry B. Pulley
13. Birthplace Boydton, Virginia.

MOTHER 14. Maiden Name Helen Butler.
15. Birthplace Calvert Co., Md.

16 (a) Informant Mrs. Henry B. Pulley.
(b) Address 1205 Nolan Court.

17 (a) Burial (b) Date thereof Mar. 26 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (b) Katie R. Williams
MAR 26 1947

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1947 at 9:45 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Ryon M.D.
Medical Examiner.
Date signed 3-24-47

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

AB-[illegible]0023 — Registered No. 47 G[illegible]0023

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4mos. 26days
(e) Length of stay in Baltimore (yrs., mos., or days) 10yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 307 North Pine Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mc Kinley Boone

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife Lillie May

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3- 1899

8. AGE: Years 48 | Months 0 | Days (365) 18 | If less than one day hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Boone
13. Birthplace Virginia

MOTHER
14. Maiden Name Sally Jenkins
15. Birthplace Virginia

16 (a) Informant Record-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 26 1947 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1947, at 10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-25- 1946 to 3-21 1947, and that I last saw h[illegible] alive on 3-21 1947

Immediate cause of death: Cancer: Metastatic to Lungs, Kidneys — Duration ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] Resident
Address Bayview City Hosp Date signed 3 [illegible] D. 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150 MAR 26 1947 Interstate Williams, Md

G50024

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61 G50024

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 335 N. Stricker Street
(c) Hospital or institution: 19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 335 N. Stricker Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARIE MIAL

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	MARRIED

6 (b) Name of husband or wife OSCAR DANIEL MIAL
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) July 4, 1885

8. AGE: Years	Months	Days	If less than one day
51	8	20	hr. min.

9. Birthplace Mt. Olive, N.C. (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name FRANK Brooks
13. Birthplace Mt. Olive, N. C.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant OSCAR D. MIAL
(b) Address 335 N. Stricker Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 27 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie N. Wilkins
(b) Address 322 N. Schroeder St

19 (a) (Date filed by registrar) (b) Registrar

MAR 26 1947

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1947, at 6:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 17 1946 to Mar 24, 1947. and that I last saw her alive on March 23 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	3 days
Due to Arteriosclerosis	Several years
Due to Diabetes Mellitus	Several years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Sept. 1946 and Feb. 1947
Major findings of operation: Gangrene of feet
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard A. Hurst M. D.
Address 1631 Franklin St. Date signed 3-25-47

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. C5D025

C5D025

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 927 Hanover St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Hoffman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widowed

6 (b) Name of husband or wife Albert

6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) 3/19/1860

8. AGE: Years	Months	Days	If less than one day
86 84	11	6	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name Thomas Fagen
13. Birthplace Md

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs Ada L Hoffman
(b) Address 927 S. Hanover St

17 (a) Burial (b) Date thereof 3/28/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location Frederick - Maryland

18 (a) Funeral director John F Dempsey Inc
(b) Address 118 Light St

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/25 1947, at 9:45 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Lybrook M.D.
Medical Examiner.
Date signed 3/28/47

VS 181 MAR 28 1947 Baltimore Williams MD

G-10026

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G-10026

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 523 Tunbridge Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 523 Tunbridge Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George P. Pliff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ella Pliff

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 18 1898

8. AGE: Years	Months	Days	If less than one day
49	-	5	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation
11. Industry or business Glue Factory

FATHER
12. Name Charles G. Pliff
13. Birthplace Baltimore

MOTHER
14. Maiden Name Nellie Henninghausen
15. Birthplace Baltimore

16 (a) Informant Ella Pliff
(b) Address 523 Tunbridge Road

17 (a) Burial (b) Date thereof 3-26-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Frederick Rd

18 (a) Funeral director John L. Morais
(b) Address 3600 E Baltimore St

19 MAR 26 1947 for Arthur Williams, M.D.
(Date received by registrar) Registrar

V S 130

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1947, at 2.25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 28 1946, to Mar. 23 1947 and that I last saw him alive on Mar. 22 1947.

Immediate cause of death	Duration
Coronary Occlusion	
Due to Arteriosclerosis & Hypertension	5 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Karl F. Benson, M.D.
Address 511 York Rd Date signed 3-24-1947

Karl F. Benson M.D.

G50027

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G50027

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 hours
(e) Length of stay in Baltimore (yrs., mos., or days) 20 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore.
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3801 Blair Road. (If rural give location)
(e) Citizen of foreign country? Yes. (Yes or No) If yes, name country Canada

3 (a) FULL NAME Mrs. Beatrice J. A. Dixon.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, (married) widowed, or divorced.

6 (b) Name of husband or wife George J. Dixon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15 — 1890

8. AGE: Years 56 | Months 8 | Days 10 | If less than one day hr. min.

9. Birthplace Ottawa Canada (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Alexander Larocque
13. Birthplace Canada

MOTHER
14. Maiden Name Mary L Dagonais
15. Birthplace Canada

16 (a) Informant Mrs George Dixon
(b) Address 3801 Belair Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-28-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director Jas. J. Heor & Son
(b) Address 3001 Pentenky ave

19 MAR 26 1947 (Date rec'd by registrar) (b) Huntington Woods Mich. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1947. at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 24 1947. to March 25 1947. and that I last saw h.e alive on March 25 1947.

Immediate cause of death	Duration
Cardiac Respiratory failure	
Due to Rheumatic Valvular Heart disease	
Due to with Cerebral vascular accident	
Other Conditions and Diabetes Mellitus (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert A. Young
Address St. Joseph Hosp. Date signed 3/26/47 (M. D.)

VS 150

92c

G50038 ✓ G50038

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6718 Youngstown Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6718 Youngstown Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Maltese

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Vincenzo Maltese
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20 1888

8. AGE: Years	Months	Days	If less than one day
58	8	4	hr. min.

9. Birthplace Trapani Italy
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Andrea Mannina
13. Birthplace Italy

MOTHER
14. Maiden Name Tomassina Camdeo
15. Birthplace Italy

16 (a) Informant Josephine Luca (Daughter)
(b) Address 6718 Youngstown Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 27/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rose
(b) Address 52 N. Morley St.

19 (a) MAR 26 1947 (Date received by Registrar) Hunter for Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1947, at 10 a M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1935 to March 24 1947 and that I last saw her alive on March 23 1947.

Immediate cause of death Diabetes Mellitus — Duration several years

Due to

Due to

Other Conditions Cerebral Hemorrhage — 2 months

(Include pregnancy within 3 months of death)
Date of operation No
Major findings of operation: —
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. G. Rosenblatt M. D.
Address 3918 Roanell St. Date signed 3-25-47

VS 150

G500,29
AB-109034

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 13B

G500,29
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 891 West Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy De Julis -or- Dorothy De Julia

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-20-0545

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife (Pete) Perino DeJulis -or- DeJulis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 23- 1921

8. AGE: Years	Months	Days	If less than one day
25	3	1	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles Birch
13. Birthplace Md.

MOTHER
14. Maiden Name Mary ? FIELDS
15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 3/26-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Beth Israel

18 (a) Funeral director Powell Bella Coal
(b) Address 52 N. Marley St

19 (a) (b)
(Date rec'd by registrar) MAR 26 1947 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1947, at 4.45AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-10- 19 47, to 3-24- 19 47, and that I last saw h. or alive on 3-24- 19 47.

Immediate cause of death Pulmonary Tuberculosis
Tuberculous Enteritis — Duration ? 4 months

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. S. Slater M. D.
Address Bal City Hosp Date signed 24 March 1947

VS 150

G50030

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G50030 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison
(c) Hospital or institution: Md Gen'l Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2204 Md. Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Elizabeth Coleman Smith

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug-28-1869

8. AGE: Years 77 | Months 6 | Days 25 | If less than one day ... hr. ... min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name Henry Smith
13. Birthplace Virginia

MOTHER
14. Maiden Name Elizabeth Coleman
15. Birthplace Maryland

16 (a) Informant Mr. J. Alex. Johnson (friend)
(b) Address 6211 Hollen Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-28-47 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore

18 (a) Funeral director Stewart Mem Co.
(b) Address 1081 W Fort Ave.

19 (a) MAR 26 1947 (Date rec'd by registrar) (b) Washington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1947, at 11:10 P.M.

21. I certify that I took charge of the remains described above, held an Aug & Insp thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic Cardio Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Fishel M.D.
Medical Examiner.
Date signed March 26, 1947

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Be sure information should be carefully supplied. The

G50031

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 ✓ Registered No. G50031

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3129 Guilford Av
(c) Hospital or institution: Home 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3129 Guilford Av (If rural, give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME Augusta Katharine Gruebel

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Emil Gruebel

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb 22 - 1862

8. AGE: Years 85 | Months 1 | Days 13 | If less than one day ____ hr. ____ min.

9. Birthplace Balto. Co. Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace Germany

16 (a) Informant Mr. Ferdinand J. Gruebel (Son)
(b) Address 632 W 111 St NY 25 NY

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-28-47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (W. F. MOWEN SUC.) 100 W. NORTH AVENUE

19 (a) MAR 26 1947 (Date rec'd by Registrar) (b) Huntington Maryland

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1947, at 8 45 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William S. Gleitsch M.D. Medical Examiner.
Date signed March 26, 1947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G50032 (G50032)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 220 Oakdale Rd.
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto City
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 220 Oakdale Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Marion Virginia Marshall

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband ~~or wife~~ Albert Marshall
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 3-2-1866

8. AGE: Years 91 | Months 9 | Days 22 | If less than one day ... hr. ... min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER 12. Name Andrew J Burke
13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Ann Louisa Airey
15. Birthplace Balto Md

16 (a) Informant Mrs. Wm C. Stewart (Daughter)
(b) Address 220 Oakdale Rd. Balto Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-25-37 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. Md.

18 (a) Funeral director Stewart & Mowen Co.
(b) Address 108 W. North Avenue

19 (a) ... (Date rec'd by registrar) (b) ... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/24 1937 at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/24 1937 to 3/24 1937 and that I last saw h[illegible] alive on 3/24 1937

Immediate cause of death	Duration
Senile Myocarditis	1 Wk
Due to Arteriosclerosis	6 mo
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. F. Workman M. D.
Address 1 E Madison Date signed 3/25/37

VS 150

X

G56033 — BALTIMORE CITY HEALTH DEPARTMENT — G56033

Registered No. 68668

CERTIFICATE OF DEATH 107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 min. 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits write RURAL, and give town)
(d) Street No. 13 N. Gilmor St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cynthia Holland (Holland)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 19, 1944

8. AGE: Years	Months	Days	If less than one day
	2	6	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation Nail ?

11. Industry or business

FATHER — 12. Name Ernest W. Holland
13. Birthplace Baltimore City Md

MOTHER — 14. Maiden Name Marie Brdue
15. Birthplace Baltimore Maryland

16 (a) Informant Mrs Marie Holland
(b) Address 139 Gilmor St

17 (a) Burial (b) Date thereof 3-29-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Star
Location Baltimore City Md

18 (a) Funeral director Joseph A. Lord
(b) Address 66 W. Lanvale St

19 (a) (Date rec'd by registrar) (b) Baltimore registrar

MAR 26 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1947, at 4:45 M

21. I certify that I took charge of the remains described above, held an Aug Ex Surg thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Broncho-Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Kelpatrick M.D.
Medical Examiner.
Date signed March 26, 1947

X

G50034

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1610

Registered No. G50034

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - 29,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4022 Cranston Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Skelly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-25-47

8. AGE: Years | Months | Days | If less than one day 5 h 8 min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Eugene Joseph Skelly
13. Birthplace Philadelphia Pennsylvania

MOTHER
14. Maiden Name Catherine Fidelis Norris
15. Birthplace Baltimore Maryland

16 (a) Informant Hospital Records
(b) Address 2025 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/26/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Leb. Frederick Rd.

18 (a) Funeral director P. J. Foley Sons
(b) Address 319 E. Lightst.

19 (a) (b)
(Date received by registrar) MAR 26 1947 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-26-47 19 4:45 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 24 1947, to Mar 26 1947, and that I last saw h alive on 19

Immediate cause of death — Duration

Respiratory failure

Due to Congenital atelectasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William P. Carr M. D.
Address Bon Secours Hosp. Date signed 3-26-47

VS 190

X

G50035

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G50035 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2010 N. Pulaski St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2010 N. Pulaski Street (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine M. Brodt

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NO

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.M	White	Widowed

6 (b) Name of husband or wife Henry Brodt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28, 1851

8. AGE: Years	Months	Days	If less than one day
95	7	25	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Unknown
13. Birthplace W

MOTHER
14. Maiden Name W
15. Birthplace W

16 (a) Informant Mrs. Carl Engelmann
(b) Address 2012 N Pulaski St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/28/47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location AACounty

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

MAR 26 1947 Livingston Williams, M.D. Registrar
(Local Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1947, at 5 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from December 1946 to March 25 1947, and that I last saw h[illegible] alive on Feb. 24 1947.

Immediate cause of death	Duration
Pneumonia	
Due to old age	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 3-26-47

VS 150

G50036

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G50036 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1004 W. Fayette St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1004 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Walker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female

5. Color or race Col.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace Alexandria, Va. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Jane Haskin
15. Birthplace Va.

16 (a) Informant Lillian Williams
(b) Address 1004 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/25/47 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location

18 (a) Funeral director Elroy C. Wilson
(b) Address 1000 Brantly Ave.

MAR 26 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1947 at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 25 1946 to March 21 1947 and that I last saw h[illegible] alive on March 21 1947.

Immediate cause of death Cardiac Vascular Disease — Duration 1 year

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Watts M. D.
Address 5154 Carlton Date signed 3/24/47

VS 150

G50037

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G50037 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Payson St
(c) Hospital or institution: Bon Secour
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 709 Cooks Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Ida C. Cook

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 14, 1871

8. AGE: Years 76 | Months 1 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name John Cook
13. Birthplace Germany

MOTHER 14. Maiden Name Elizabeth Pfeiffer
15. Birthplace Maryland

16 (a) Informant Miss Belle Cook
(b) Address 709 Cooks Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 28/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto. Md.

18 (a) Funeral director: Harry A. Wittstadt
(b) Address 1101 E. Lanvale Ave

19 (a) 3/27/47 (Date received by registrar) (b) for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 March 1947, at 1 55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7 March 1947, to 26 March 1947, and that I last saw her alive on 26 March 1947.

Immediate cause of death	Duration
Cardiac failure	
Due to, Myocardial insufficiency.	
Due to	
Other Conditions — Fracture rib 3 weeks ago	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 28/4
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 3/7/47 at 7:30 A.M.
(c) Where did injury occur? 709 Cooks Lane
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Means of injury Slipped and fell to floor
23. Signature Joseph R. Liberto M.D.
Address 13 E. Saratoga Date signed 26 March 1947

Howard J. Williams, M.D.

G50038 BCHD-45419

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

106c

G50038 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 11 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balt. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3800 Towanda Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Barbara Covey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/13/46

8. AGE: Years	Months	Days	If less than one day
0	11	12	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Covey
13. Birthplace Md

MOTHER
14. Maiden Name Beatrice Teel
15. Birthplace Md

16 (a) Informant Mrs Beatrice Teel
(b) Address 3800 Towanda Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 27-1947 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Baltimore Co.

18 (a) Funeral director Maurice B. Seyfert
(b) Address 1600 W. Baltimore St

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 26 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/25 1947 at 6 03 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/23 1947 to 3/25 1947 and that I last saw her alive on 3/25 1947

Immediate cause of death: Cardio-resp. failure — Duration

Due to: Laryngo-Trachio bronchitis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Emma R Jennings M. D.
Address Univ. Hospital Date signed 3/25/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50039

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G50039 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 112 S. Broadway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 112 S. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME KATIE ANNIE HOENER

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Frederick G. Hoener
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Mar. 4. 1863

8. AGE: Years: 84 | Months: 0 | Days: 19 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Christopher Diering
13. Birthplace: Germany

MOTHER
14. Maiden Name: Anna E. Topher
15. Birthplace: Germany

16 (a) Informant: Mrs. Martha Doedeke
(b) Address: 112 S. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Mar. 28, 1947 (month) (day) (year)
(c) Cemetery or crematory: St. Mathews Cem
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS. INC.
(b) Address: Baltimore Md.

19 (a) (Date rec'd by registrar) MAR 26 1947 (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 23. 1947 at 8.30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 1940 to Mar 23 1947. and that I last saw h[illegible] alive on Mar. 22 1947.

Immediate cause of death	Duration
Cardio-Vascular Hypertension Disease	5 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Homer L. Dodd M. D.
Address 2108 St Paul St Date signed 3-26-47

X

G50010 BH 050040

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1600a

Registered No. 16092 G50010

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edmondson Ave
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 27/24 d
(e) Length of stay in Baltimore (yrs., mos., or days) 1 27/24 d

2. USUAL RESIDENCE OF DECEASED:
(a) State MC (b) County Howard
(c) City or town Ellicott City
(If outside city or town limits, write RURAL and give town)
(d) Street No. old Frederick Rd
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Williams

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife
6 (c) If married, widowed, or divorced, how long years

7. Birth date of deceased (mo., day, yr.) 3/23/47 (1 hour)

8. AGE: Years | Months | Days 2 1/24 | If less than one day hr. min.

9. Birthplace Oakland MC
(Town, county, and state)

10. Usual Occupation
11. Industry or business None

FATHER
12. Name Jesse Tyson Williams
13. Birthplace Rutledge Tenn

MOTHER
14. Maiden Name Hebe Flora Hipshire
15. Birthplace Rutledge Tenn

16 (a) Informant Helen Williams
(b) Address Ellicott City MC

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-27-47 (month) (day) (year)
(c) Cemetery or crematory Good Shepherd
Location Ellicott City Md

18 (a) Funeral director J.C. Hayes Undertaking
(b) Address Ellicott City Md

19 (a) (Date rec'd by registrar) MAR 26 1947 (b) Registrar Huntington Hillsman, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/23 1947 to 3/25 1947 and that I last saw h/M alive on 3/25 1947

Immediate cause of death Intracranial Hemorrhage — Duration

Due to

Due to

Other Conditions
(Include pregnancy within past year of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Ellicott City Md Date signed

G50011

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G50011 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1943 W. Mulberry St.,
(c) Hospital or institution: 70
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1943 W. Mulberry St.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes Theresa Coyne Griffith

3 (b) If veteran, name war: --

3 (c) Social Security Account No. 213-03-3556

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Arthur L. Griffith
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) January 17, 1894

8. AGE: Years 53 | Months 2 | Days 7 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Co., Md.
(Town, county, and state)

10. Usual Occupation Candy Packer

11. Industry or business Martha Washington Candy

FATHER
12. Name Jerome Coyne
13. Birthplace Baltimore Co., Md.

MOTHER
14. Maiden Name Ellen Doyle
15. Birthplace Baltimore Co., Md.

16 (a) Informant Mr. Arthur L. Griffith
(b) Address 1943 W. Mulberry St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-27-47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn, Md.

18 (a) Funeral director L. Howard Strong
(b) Address 3207 W. North Ave.,

19 (a) (Date received by registrar) MAR 26 1947 (b) Huntington Williams

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24, 1947, at 9.25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/17 1947 to 3/24 1947 and that I last saw her alive on 3/24 1947.

Immediate cause of death	Duration
Arteria-sclerotic Cardio-vascular disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wayne Laughlen M.D.
Address 404 N. Payson St. Date signed 3/26/47

G50042

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G50042 Registered No. 24747

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1024 E. Monument St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1024 E. Monument (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Thomas Peed

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	C.	W

6 (b) Name of husband or wife Susie
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 11, 1863

8. AGE: Years	Months	Days	If less than one day
83	8	13	— hr. — min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Peed
13. Birthplace Virginia

MOTHER
14. Maiden Name Butler
15. Birthplace St. Mary Co. Maryland

16 (a) Informant Helen Campbell
(b) Address 1024 E. Monument St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 27 47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location Old Frederick Road

18 (a) Funeral director Mrs. Robt A. Elwood Dft
(b) Address 1129 N Caroline St.

19 (a) Filed MAR 26 1947 Huntington Hollins Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1947, at 7:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-15 1944 to 3-20 1947, and that I last saw him alive on 3-20 1947.

Immediate cause of death	Duration
Coronary Thrombosis	unknown
Due to Arteriosclerosis	
Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R B Lightsalor M. D.
Address 501 Cherry Hill Rd Date signed 3-24-47

VS 150

X

G50013

AB-109159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1462

G50013

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9days
(e) Length of stay in Baltimore (yrs., mos., or days) 15yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1639 E. Eager St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ieva White

S 34287

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife: Clarence White

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24- 1915

8. AGE: Years 31 | Months 3 | Days 0 | If less than one day hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Floyd Jones
13. Birthplace N.C.

MOTHER
14. Maiden Name Perthenia Brown
15. Birthplace N.C.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof March 26/47 (month) (day) (year)

(c) Cemetery or crematory
Location Rocky Mount N. Carolina

18 (a) Funeral director Wm. Robt. A Elliott Sons
(b) Address 1129 N. Caroline St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24- 1947 at 3.42A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-15- 1947 to 3-24- 1947 and that I last saw her alive on 3-24- 1947

Immediate cause of death Intra partum and Post Partum Hemorrhage — Duration

Due to Premature Expulsion of Placenta

Due to Uterine atony

Other Conditions Precipitate Labor

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benjamin H. Jones Jr M.D.

Address Balt. City Hosp. Date signed 3/25/47

VS 150

AB- 43935 G50014

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G50014 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7yrs-11mos-6days
(e) Length of stay in Baltimore (yrs., mos., or days) 52yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1018 McDonogh Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Henry Holoby

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22-1859

8. AGE: Years	Months	Days	If less than one day
88	1	2	hr. min.

9. Birthplace N.C.
(Town, county, and state)
10. Usual Occupation O.A.P.
11. Industry or business

FATHER
12. Name Sidney Holoby
13. Birthplace N.C.

MOTHER
14. Maiden Name Lucy ?
15. Birthplace N.C.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 3/28/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cems.
Location Balto Co Md

18 (a) Funeral director Mrs Ruth G. Edwards
(b) Address 1129 N. Caroline St

19 (a) 6 1947 (b) Jos. Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1947, at 4:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-18 1939, to 3-24- 1947, and that I last saw him alive on 3-24-47 1947.

Immediate cause of death	Duration
Myocardial Infarction	
Due to Generalized Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. Rowe Hull M.D.
Address Baltimore City Hosp. Date signed 3-24-47

VS 150

G50015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G50015 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Lexington Sts
(c) Hospital or institution: Mercy Hosp 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2811 Booker Drive, Cherry Hill
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Sallie Burns

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-29-13

8. AGE: Years 33 | Months 2 6 | Days 30 29 | If less than one day hr. min.

9. Birthplace Goshen N. Carolina (Town, county, and state)

10. Usual Occupation Maid

11. Industry or business Hospital

FATHER 12. Name James Burns

13. Birthplace N. Car.

MOTHER 14. Maiden Name Lizzie Blackman

15. Birthplace N. Car.

16 (a) Informant Self.

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 27/47 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem

Location Balto Co.

18 (a) Funeral director Wm. H. Allen Funeral

(b) Address 1129 N. Caroline St

19 (a) MAR 26 1947 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1947, at 7:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-7 1947 to 3-23 1947 and that I last saw h[illegible] alive on 3-23 1947.

Immediate cause of death Embolism - Duration 2 days
(a) Pulmonary

Due to Recto-Vaginal Fistula 1 yr.
(b)

Due to Carcinoma of Cervix 6 yrs.
(c)

Other Conditions Colostomy
(Include pregnancy within 3 months of death)

Date of operation 2-7-47

Major findings of operation: Closure of Colostomy

Date of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William D. Kenley M.D.

Address Mercy Hosp Date signed 3-29-47

VS 150

Huntington-Williamsville, Md

X

G.0016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G.0016 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5013 Walther Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 80 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5013 Walther Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Doell

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Louis Weamert
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) May 3rd. 1857

8. AGE: Years 89 | Months 10 | Days 22 | If less than one day ##### hrs. ..... min.

9. Birthplace Virgina (Town, county, and state)
10. Usual Occupation Stone cutter (Retired)
11. Industry or business

FATHER
12. Name William Doell
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Gertrude J. Derringer
(b) Address 5013 Walther Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/28/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. North Avenue Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

MAR 26 1947

V-S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25th., 1947, at ..... M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946 to 3/25 1947 and that I last saw h[illegible] alive on 3/25 1947

Immediate cause of death Hypostatic Pneumonia
Cardio-Vascular Disease — Duration .....
Due to ..... — Duration .....
Due to ..... — Duration .....
Other Conditions ..... — Duration .....
(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Alphonse Feeley M. D.
Address 5203 Harford Ave. Date signed 3/25/47

X

G50017

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G50017

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 D
(e) Length of stay in Baltimore (yrs., mos., or days) 20 D

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County.....
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 622 S. Wolfe
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME MARIAN ANDERSON (Mary Alexander)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife. John Alexander

6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) May 15, 1902

8. AGE: Years 44 | Months 10 | Days 29 | If less than one day ....hr. ....min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name August Yevorovski
13. Birthplace Poland

MOTHER
14. Maiden Name Mary Fisher
15. Birthplace Poland

16 (a) Informant Agnes Gilbert
(b) Address 1405 Cookson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/47 (month) (day) (year)

(c) Cemetery or crematory Holy Cross
Location Annapolis Blvd.

18 (a) Funeral director Chas. F. Dill
(b) Address 1501 E. Fort Ave.

19 (a) ....(Filed by Registrar) (b) .... Registrar

MAR 26 1947

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/24/47 19.... 8:25 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute cardiac failure

Due to Myocardial degeneration

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature John R. Ivens M.D.
Medical Examiner.

Date signed 3/25/47

X

correct age is especially important. Physicians: please write the

G50018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164a

Registered No. G50018

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8'
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1725 N Caroline (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** ERNEST FLOWERS

3 (b) If veteran, name war —

3 (c) Social Security Account No. 218-10-6354

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Eleanor R. Flowers

6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) September 8, 1897

8. AGE: Years 49 | Months 6 | Days 16 | If less than one day hr. min.

9. Birthplace Harford Co, Md. (Town, county, and state)

10. Usual Occupation Packer

11. Industry or business

FATHER
12. Name Harry E. Flowers
13. Birthplace Harford Co. Md.

MOTHER
14. Maiden Name Lulla Duff
15. Birthplace Harford Co. Md

16 (a) Informant Mrs. Leonard L. Flowers
(b) Address 1725 N. Caroline St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-27-47 (month) (day) (year)
(c) Cemetery or crematory Loch M.E.
Location Loch, Md.

18 (a) Funeral director Frederick A. Cole
(b) Address 2100 N. Lombard St

19 (a) (Date received) MAR 28 1947 Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/24/47 19 , at 6:10 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Strangulation

Due to Hanging by Rope

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/24 at 3:30 P.M.
(b) Where did injury occur? 1725 N. Harford St.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial place (While at work?) Yes
(d) Means of injury Self Inflicted

23. Signature John Beans, M.D. Medical Examiner.
Date signed 3/27/47

X

Please write the causes of death clearly and legibly. Physicians: please write the cause of death in such a way that the correct age is especially important. Physicians: please write the cause of death clearly and legibly. Use

G50019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G50019

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4901 Harford Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4901 Harford Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Carrie L. Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 19, 1863

8. AGE: Years	Months	Days	If less than one day
83	11	6	hr. min.

9. Birthplace England
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Carrie L. Smith
(b) Address 4901 Harford Road, -14-

17 (a) Burial (b) Date thereof 3/28/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Friends Burial Cem.
Location Harford Road, Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14-

19 (a) (b)
(Date received by Registrar) Registrar

MAR 26 1947

V S 190

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 21 1947 to March 25 1947, and that I last saw h[illegible] alive on March 25 1947.

Immediate cause of death	Duration
Bronchopneumonia	5 days
Due to Grippe	5 days
Due to	
Other Conditions Chronic nephritis; Cerebral arteriosclerosis	7 years

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George Sawyer, M.D.
M. D.
Address 4808 Harford Rd. Date signed 3/26/47

33a

G50060

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

G50060 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or instit. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) 29 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1518 Hollins St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Lee Nicodemus

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	

6 (b) Name of husband or wife Lucy Nicodemus
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1877

8. AGE: Years	Months	Days	If less than one day
69	10	10/13	hr. min.

9. Birthplace W. Va.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Alfonso Nicodemus
13. Birthplace Maryland

MOTHER
14. Maiden Name Virginia Minaghini
15. Birthplace W. Va.

16 (a) Informant Lucy Nicodemus
(b) Address 1518 Hollins St. - Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch. 27-47 (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Dorsey Rd

18 (a) Funeral director Geo. L. Berger Jr
(b) Address 1512 Hollins St

19 (a) (Date rec'd by registrar) (b) Registrar Christopher Williams, M.D.

MAR 26 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-23 1947 at 5:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-4 1947 to 3-23 1947 and that I last saw him alive on 3-23 1947

Immediate cause of death: Adenocarcinoma Prostate — Duration 19 da.
Due to
Due to
Other Conditions Chr. Bronchitis
(Include pregnancy within 3 months of death)

Date of operation 3-6-47
Major findings of operation: Adenocarcinoma Prostate
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury

23. Signature Stanley B. Kyanowski M.D.
M. D.
Address Franklin Sq Hosp Date signed 3-23-47

Birth Certificate G-74195

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160c

Registered No. 50051

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3456 Chesnell Ct
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto 25 Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3456 Chesnell Ct
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Smith (girl)

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 20 47

8. AGE: Years | Months | Days | If less than one day 3 hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name James Elmo Smith
13. Birthplace Idaho, Penn.

MOTHER
14. Maiden Name Helen Koung
15. Birthplace Ashland, Ky

16 (a) Informant James Elmo Smith
(b) Address 3456 Chesnell Ct

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School MAR 24 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 26 1947 (Date Rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 20 1947, at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 20 19 to Mar 20 19, and that I last saw h[illegible] alive on Mar 20 47

Immediate cause of death: prematurity

Due to premature rupture of membranes

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 352 Tatapeveller Date signed Mar 20 47

X

G50052 Ltr 7361 ✓160

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G50052

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave 16
(c) Hospital or institution: West Balto Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town 3440 Greenlow Ave
(If outside city or town limits, write RURAL and give town)
(d) Street No. Chesley (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Huddy

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-16-47

8. AGE: Years	Months	Days	If less than one day
		0	4 hr. 5 min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER 12. Name Maurice Huddy

13. Birthplace Penna

MOTHER 14. Maiden Name Clementine Simon

15. Birthplace Penna

16 (a) Informant

(b) Address 3440 Chesley Ave 26

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location Johns Hopkins Medical School MAR 24 1947

18 (a) Funeral director Commissioner of Health

(b) Address

MAR 26 1947 Huntington Williams M.D.
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-16 1947, at 7:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-16 1947 to 3-16 1947 and that I last saw h/him alive on 3-16 1947

Immediate cause of death	Duration
Atelectasis	
Due to Intra Uterine asphyxia	
Due to Placenta Praevia	
Other Conditions Breeding	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Atelectasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. D. Trego M. D.

Address W. Balto Gen Hosp Date signed 3-21

VS 130

X

G50053 Died
Bl# 250053

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 161a

Registered No. G50053

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home & Hospital 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 50 min
(e) Length of stay in Baltimore (yrs., mos., or days) "

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto City
(c) City or town Balto. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2055 So. Spring Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Hammond.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 3/21/47

8. AGE: Years	Months	Days	If less than one day
—	—	—	hr. 50 min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Grady H. Hammond.
13. Birthplace Marion, Virginia

MOTHER
14. Maiden Name Mary Elizabeth Wilson
15. Birthplace Bellington, West Virginia

16 (a) Informant Mrs. Betty V. Hammond
(b) Address 2055 S. Spring Court City.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 (Date rec'd by registrar) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/21/47 19 . at 6 3/4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/21/47 19 to 3/21/47 19 , and that I last saw h[illegible] alive on 3/21/47 19 .

Immediate cause of death: Respiratory failure — Duration

Due to atelectasis, bilateral

Due to congenital anomalies pulmonary & lungs

Other Conditions pulmonary edema

(Including pregnancy within 3 months of death)

Date of operation 3/21/47

Major findings of operation:

of autopsy: pulmonary edema, atelectasis

PHYSICIAN
Underline the cause to which death should be charged and give address.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph D. Patterson M.D.
Address Church Home & Hosp. Date signed 3/21/47

Johns Hopkins Medical School MAR 24 1947
Commissioner of Health
MAR 26 1947
(Date rec'd by registrar)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G50054 | BALTIMORE CITY HEALTH DEPARTMENT | G50054

CERTIFICATE OF DEATH 55c

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2601 Park Heights Terrace
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 2601 Park Heights Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Berman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lea

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 68 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Jankel
13. Birthplace Russia

MOTHER
14. Maiden Name Hayes
15. Birthplace Russia

16 (a) Informant Elias Berman
(b) Address 2601 Park Heights Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-27-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1629 E Baltimore St

19 (a) (b)
(Date rec'd by registrar) Registrar

3 26 1947
VS 150

Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-26- 1947, at 2A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to 3-26 1947 and that I last saw h[illegible] alive on 3-26 1947.

Immediate cause of death: Carcinoma of Thyroid — Duration 8 mos.

Due to:

Due to:

Other Conditions None

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:

of autopsy: None.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leon Asbuman M. D.
Address 201 Poplar Ave Date signed 3-26-47

X

G50055

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1216

G50055 Registered No.

PLEASE: WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2027 Madison Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city limits, write RURAL and give town)
(d) Street No. 2027 Madison Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Viola G. Hise

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17, 1893

8. AGE: Years 54 | Months - | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Business woman

11. Industry or business

FATHER 12. Name Randolph Thompson

13. Birthplace St. Mary's Co. Md.

MOTHER 14. Maiden Name Isabella Voter

15. Birthplace Nelson Co. Va

16 (a) Informant James L. Hise

(b) Address 2027 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/28/1947 (month) (day) (year)

(c) Cemetery or crematory St. Peters

Location Baltimore, Md.

18 (a) Funeral director Mrs. Lew. A. Hallowell

(b) Address 1631 Druid Hill Ave.

19 (a) (Date received by registrar) MAR 26 1947 (b) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 23, 1947, 3:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 8, 1947 to Mar. 23, 1947, and that I last saw h.E.I. alive on Mar. 22, 1947

Immediate cause of death Pulmonary Tuberculosis — Duration: A number of years

Due to "

Due to "

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Greenfield M. D.

Address 1821 Eutaw St. Date signed 3/26/47

X

G50056

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G50056 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 117 N. Carrollton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 24, 1886

8. AGE: Years	Months	Days	If less than one day
60	7	-	hr. min.

9. Birthplace British West Indies (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mary Connor
(b) Address 253 E. Fremont St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/28/47 (month) (day) (year)
(c) Cemetery or crematory Bals. National
Location Bals. Md.

18 (a) Funeral director Chas. H. Stallings
(b) Address 163 E. Monument St.

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 26 1947

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1947, at 1 05 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

Signature Earl Royer M.D.
Medical Examiner.
Date signed 3-24-47

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50057

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G50057 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Lockeysville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Cuba Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Chester Powell

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	—

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-15-47

8. AGE: Years	Months	Days	If less than one day
	2	11	hr. min.

9. Birthplace Co. Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name James Powell
13. Birthplace Md

MOTHER 14. Maiden Name Edna Howard
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 3-25-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lutheran Loudon Park
Location

18 (a) Funeral director Gaston W. Brown
(b) Address [illegible] Williams, M.D.

19 (a) 1947 (b)
(Date filed by registrar) Registrar

3 26 47

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar-26 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 23 1947 to Mar 27 1947 and that I last saw h. alive on Mar 27 1947.

Immediate cause of death	Duration
Broncho pneumonia	
? Aspiration	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry Rumpel M. D.
Address Johns Hopkins Hosp Date signed 3-26-47

for Greenhalgh

G50058
512177

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1332 X G50058 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State N. J. (b) County.....
(c) City or town Ventnor
(If outside city or town limits, write RURAL and give town)
(d) Street No. 109 S Frankfort ave
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Bertha de Kellebrenth
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife.....
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 4-25-1874
8. AGE: Years 72 Months 11 Days 1 If less than one day hr. min.
9. Birthplace Hungary (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business
FATHER 12. Name Alexander Habrovszky
13. Birthplace Hungary
MOTHER 14. Maiden Name Bertha de Buchwald
15. Birthplace Hungary
16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Removal (b) Date thereof Mar 26 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Atlantic City N.J.
Location.....
18 (a) Funeral director Henry W Lenkey Sons
(b) Address McCulloh & Orchard
19 (a)..... (b).....
(Date rec'd by registrar) Registrar
MAR 26 1947 Huntington Williams, M.D.

MEDICAL CERTIFICATION
20. DATE OF DEATH Mar. 26 1947 at 1.45 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Mar 23 1947 to Mar 26 1947 and that I last saw h[illegible] alive on Mar 27 1947

Immediate cause of death	Duration
Circulatory collapse	1 hr
Due to post operative hemorrhage	
Due to nephrectomy	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 3-26-47
Major findings of operation: Cancer
of autopsy: Pyonephrosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature Howard C. Goodwin M. D.
Address Johns Hopkins Hosp Date signed 3-26-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X '47

G50059

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V92B

G. 0079 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1026 E. Monument St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10-2
(e) Length of stay in Baltimore (yrs., mos., or days) 4 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1026 E. Monument St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cora Blackwell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col.	W.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7 1889

8. AGE: Years	Months	Days	If less than one day
57 58	8		hr. min.

9. Birthplace Warren, N. C. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Solomon Tally
13. Birthplace N.C.

MOTHER
14. Maiden Name Elvina Jefferson
15. Birthplace N.C.

16 (a) Informant Elizabeth Ellis
(b) Address 1026 E. Monument St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/26/47 (month) (day) (year)
(c) Cemetery or crematory
Location Petersburg, Va.

18 (a) Funeral director Elroy C. Wilson
(b) Address 1000 Brantly Ave.

19 (a) 4047 (Date rec'd by registrar) Thurston Williams, M.D. Registrar

3/26/47

MEDICAL CERTIFICATION 11 P.M.

20. DATE OF DEATH March 21 1947, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 3 1947, to March 21 1947, and that I last saw h[illegible] alive on March 20 1947.

Immediate cause of death	Duration
Auricular fibrillation	1 day
Due to Mitral Regurgitation	unknown
Due to	
Other Conditions Cerebral Hemorrhage (Include pregnancy within 3 months of death)	10 yrs.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. C. Burwell.
Address 171 Augusta Date signed 3/26/47 M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

C50060 | BALTIMORE CITY HEALTH DEPARTMENT | Registered No. C50060

CERTIFICATE OF DEATH 48a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 425 E. Lake Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 425 E. Lake Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna M. Wich

3 (b) If veteran, name war -

3 (c) Social Security Account No. -

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife John F. Wich

6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Sept 28, 1906

8. AGE: Years 40 | Months 5 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Andrew Gerstbrich
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name [redacted] Rose Neering
15. Birthplace Baltimore Md.

16 (a) Informant John F. Wich
(b) Address 425 E. Lake Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 28 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Road

18 (a) Funeral director Mr. & Mrs. John W. Heufelder Son
(b) Address 5311 Edmondson Ave

19 (a) (Signature of registrar) (b) Registrar

MAR 27 1947

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 25 1947, at 6 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1946 to Mar 25 1947, and that I last saw [illegible] alive on Mar 25 1947

Immediate cause of death: Carcinoma, cervix uteri — Duration 16 mo.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Nov. 1945

Major findings of operation: Carcinoma, cervix uteri

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John W. Parsons M. D.

Address 1109 St. Paul St Date signed Mar 26, 47

X

G50061

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G50061

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1920 Lemmon Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 - 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1920 Lemmon Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George W. Simmons

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Widowed

6 (b) Name of husband or wife Ida V. Simmons
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15, 1859

8. AGE: Years	Months	Days	If less than one day
88	2	10	hr. min.

9. Birthplace Eastern Shore, Maryland (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business Himself

FATHER
12. Name Unknown Simmons
13. Birthplace Unknown

MOTHER
14. Maiden Name Mary E. Frazer
15. Birthplace Unknown

16 (a) Informant Mrs. Emma Long
(b) Address 1031 Hollins Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/28/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) MAR 27 1947 (Date rec'd by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 25 1947, at 7? M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947, to Mar 25 1947, and that I last saw h— alive on Mar 24 1947.

Immediate cause of death	Duration
Pneumonia	
Due to	
Due to Cerebral Thrombosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. A. French M.D.
Address 737 Carroll Date signed 3/26/47

Huntington Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50068

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

✓ G50062 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 817 St. Paul Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 817 St. Paul Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William S. Hess

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Bessie M. Hess
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) October 31, 1872

8. AGE: Years 74 | Months 4 | Days 25 | If less than one day ... hr. ... min.

9. Birthplace Harrisburg, Pennsylvania (Town, county, and state)
10. Usual Occupation Produce Broker
11. Industry or business

FATHER
12. Name Philip Hess
13. Birthplace Harrisburg, Pennsylvania

MOTHER
14. Maiden Name Nancy Unknown
15. Birthplace Unknown

16 (a) Informant Paul S. Lake
(b) Address 710 Dunkirk Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/28/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Woodlawn, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) MAR 27 1947 (b) Huntington Wilson Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26, 1947, at 7:30 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 1 1947 to March 26 1947, and that I last saw him alive on March 25 1947.

Immediate cause of death: Cerebral Hemorrhage — Duration: Thirty days
Due to: Cerebral Arteriosclerosis — Duration: 2 years
Due to: Age — Duration:
Other Conditions: Arteriosclerosis — Duration:

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature P. S. Lake, M.D.
Address 710 Dunkirk Road, Baltimore, Md. (Signed)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C50033 ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159 D

Registered No. C50033

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) 27 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1100 Hewitt Way #5 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES JOHN TERZIO
Baby Boy Terzio - Elizabeth or Baby Boy Terzio

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 27, 1947

8. AGE: Years | Months | Days: 27 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Victor Patrick Terzio
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Fyget
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/28/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 217 St. Paul St

19 (a) 3-27-1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 19 47, at 6:30P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 28 19 47, to March 25 19 47, and that I last saw him alive on March 25 19 47.

Immediate cause of death: Asphyxiation
Premature
Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Duration: 2 hours 4 min.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Julian P. Griffin M. D.
Address Balt. City Hospitals Date signed 26 May '47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50064

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51B

Registered No. G50064

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1303 Carey St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1303 Carey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Jacob Miller

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: none
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Elsie E
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 8 1887
8. AGE: Years 60 | Months 8 | Days 19 | If less than one day: hr. min.
9. Birthplace Litnalton Va (Town, county, and state)
10. Usual Occupation Horse Shoer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Va

MOTHER
14. Maiden Name Mary Walz
15. Birthplace Va

16 (a) Informant Elsie Miller
(b) Address 1303 E Carey St.
17 (a) Final (burial, cremation, or removal) (b) Date thereof 3/27/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md
18 (a) Funeral director Wilson Cook Co
(b) Address 1317 E Pratt St
19 (a) (Date rec'd by registrar) (b) Registrar

MAR 29 1947

VS 150

Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1947, at 8 25 M
21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1 1947 to March 25 1947 and that I last saw h— alive on March 24 1947.

Immediate cause of death	Duration
Metastatic Carcinoma of Lung.	
Ca - Prostate	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Lee Lord Huntsworth M. D.
Address 2579 Eastern Ave. Date signed

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93a

Registered No. G50065

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1601 McKean Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 70 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1601 McKean Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY ELIZABETH YOCKEL

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	Widowed

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband ~~Charlie~~ Augustus W. Yockel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 21, 1876

8. AGE: Years	Months	Days	If less than one day
70	7	2	hr. min.

9. Birthplace Baltol Md. (Town, county, and state)
10. Usual Occupation Home
11. Industry or business

FATHER
12. Name Henry Meyer
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Leimback
15. Birthplace Germany

16 (a) Informant Mrs. Julia Miller
(b) Address 1940 Hollins St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/47 (month) (day) (year)
(c) Cemetery Loudon Pk. Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md.

19 (a) (Date received by Registrar) MAR 27 1947 (b) Registrar's No.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 23, 1947, at 7:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 16 1947 to March 23 1947 and that I last saw h[er] alive on March 23 1947

Immediate cause of death	Duration
Acute Myocarditis c	1 week
Due to failure	
Due to	
Other Conditions Hypostatic Pneumonia	2 days

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Adelman M.D.
Address 1601 McKean Ave Date signed 3/26/47

G50066 V G50066

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 322 Pearl St
(c) Hospital or institution: 4

(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 322 Pearl St
(If rural give location)
(e) Citizen of foreign country? Md. (Yes or No)
If yes, name country .....

3 (a) FULL NAME Pansy Pulley

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: F

5. Color or race: Col

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Elmer Pulley

6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) 3-24-07

8. AGE: Years 40 | Months - | Days 2 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business —

FATHER
12. Name Bassie Williams
13. Birthplace Maryland

MOTHER
14. Maiden Name Alvegita ?
15. Birthplace Maryland

16 (a) Informant Elmer Pulley
(b) Address 322 Pearl St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/31/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemet
Location Addr Hill, Md.

18 (a) Funeral director A. J. Gabriel
(b) Address 918 Druid Hill Ave.

19 (a) ..... (Date received by registrar) (b) 4/2/47 Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-26- 1947, at 2 00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-14- 1943 to 3-26- 1947 and that I last saw h er alive on 3-24- 1947.

Immediate cause of death: Hypertensive Heart — Duration: 3 yrs.

Due to .....

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature George C. Page, M.D.
Address 1816 N. Mount St Date signed 3-26-47.

VS 150

X

G50067

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

✓ G50067 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A
(b) Street address 1005 W. Lombard St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 18 3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1005 W. Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Adam Smith

3 (b) If veteran, name war #1

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 17 - 1890

8. AGE: Years 56 Months 6 Days 8 If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Electrician

11. Industry or business Fidelity Trust Co

FATHER
12. Name William Smith
13. Birthplace Baltimore

MOTHER
14. Maiden Name Unknown
15. Birthplace Baltimore Md

16 (a) Informant Mrs. Mary J. Smith
(b) Address 1005 W. Lombard St.

17 (a) Burial (b) Date thereof 3/29/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore City
Location 5501 Reisterstown Rd

18 (a) Funeral director John J. Cowan & Son
(b) Address 2403 Pollitus St

19 (a) MAR 27 (b) 1947 Hunting for Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/25 1947, at 9:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Acute Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature R. J. Finkbinder M.D.
Medical Examiner.
Date signed 3/26/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

650068
FL - 96968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

650068
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 26-12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 1- 25
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. No Home Address (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Caddell Stern

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Carlton (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 28, 1876

8. AGE: Years	Months	Days	If less than one day
70	5	28	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business at home

FATHER
12. Name John Tyrrell
13. Birthplace Ireland

MOTHER
14. Maiden Name Anne Droney
15. Birthplace Ireland

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 4300 Old York Rd
18 (a) Funeral director Leland E. Conner & Co
(b) Address 901-03 E. Oldenwald

19 (a) MAR 27 1947 (Date rec'd by registrar) (b) Clinton Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1947, at 12:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 31 1946 to March 26 1947, and that I last saw her alive on March 26 1947

Immediate cause of death	Duration
Bronchopneumonia	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. Russell Hoffman M. D.
Address Baltimore City Hosp. Date signed 28 Mar 47

VS 150

G50069 BALTIMORE CITY HEALTH DEPARTMENT G50069
CERTIFICATE OF DEATH 131a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 6-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6 N. Bethel Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HATTIE WILLIAMS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John Williams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years 52 | Months | Days | If less than one day hr. min.

9. Birthplace Green Ville, N. C. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name unknown
13. Birthplace N. C.

MOTHER
14. Maiden Name Harnett —
15. Birthplace N. C.

16 (a) Informant Sarah Kesse
(b) Address 3213 - Tenth st. Fairfield

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location West Port - Balto. Md.

18 (a) Funeral director Metropolitan Funeral Home Inc.
(b) Address 927 N. Mount st.

19 (a) MAR 27 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26, 1947, at 8.30 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cerebral hemorrhage

Due to Hypertensive cardiovascular renal disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George B. Merrill M.D. Medical Examiner.
Date signed 3-26-47

VS 151

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50070

509813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G50070

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 630 Aldenshot Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward R. Insley.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-16-8094

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ethel E. Insley

6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) 10-26-03

8. AGE: Years 43 | Months 5 | Days 1 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Grade Keeper

11. Industry or business Independent Ice Co.

FATHER 12. Name Reuel W Insley

13. Birthplace Md

MOTHER 14. Maiden Name Mary E O'Neill

15. Birthplace Md

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 29-1947 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore Maryland

18 (a) Funeral director Bussey Funeral Home

(b) Address 4604 Falls Road

19 (a) MAR 27 1947 (Date rec'd by registrar) (b) Huntington Wilson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1947, at 9.10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 11 1947, to March 27 1947, and that I last saw him alive on March 27 1947.

Immediate cause of death	Duration
Uremia	1 mo.
Due to Renal failure	
Due to Hypertensive cardiovascular disease	10 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 2-21 & 3-7-47

Major findings of operation: Hypertensive vascular disease

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Gordon E Sokeyer MD

Address Johns Hopkins Hosp. Date signed 3/29/47

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50071

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G50071

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3606 Roland Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3606 Roland Avenue
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles H. Benson

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 19-1861

8. AGE: Years 85 | Months 11 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore Co. Maryland (Town, county, and state)
10. Usual Occupation Merchant
11. Industry or business Retired

FATHER
12. Name John P. Benson
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah Elizabeth Gorsuch
15. Birthplace Maryland

16 (a) Informant Mrs. Gertrude E. Penn
(b) Address 3606 Roland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 27-1947 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3431 Falls Road

19 (a) MAR 27 1947 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25- 1947 at 6.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 22 1947 to Mar 25 1947 and that I last saw h[illegible] alive on Mar 24 1947

Immediate cause of death
Pulmonary embolism — Duration 1 hr.
Due to Cardio-vascular renal disease. — Duration 10 yrs.
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. H. Von Deele, M. D.
Address 3606 W. Date signed 3/24/47

VS 150

Lexington Hills, Md.

J. H. VON DEELE

The G50072

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. G5D072

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 310 W. Madison St.
(c) Hospital or institution: Maryland General Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 15
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2405 Ken Oak Rd #9 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Celia Matilda Gladfelter

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 6-15-1862

8. AGE: Years	Months	Days	If less than one day
84	9	11	— hr. 1 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Reuben Gladfelter
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elizabeth Rowe
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Helen V. Taylor
(b) Address 2405 Ken Oak Rd #9

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 28-1947 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) MAR 27 1947 (Date rec'd by registrar) Huntingtown, Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-26 1947 at 10:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/13 1947 to 8/26 1947, and that I last saw h[illegible] alive on 3-26 1947.

Immediate cause of death Chronic myocarditis,

Due to

Due to

Other Conditions Adenocarcinoma of Rectum.
(Include pregnancy within 3 months of death)

Date of operation 3-26 & 3-19-47.

Major findings of operation: Adeno Ca of rectum

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Geo A Maxwell M.D.
Address U of Md Hospital Date signed 3/24/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G-100293

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G50073 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2315 E. Monument St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mamie Vain

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 15, 1876

8. AGE: Years	Months	Days	If less than one day
70	3	10	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Winfred Scott Vain
13. Birthplace Md.

MOTHER 14. Maiden Name Charlotte Strakey
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 28-47 (month) (day) (year)
(c) Cemetery or crematory Dod Town
Location Eastern Ave.

18 (a) Funeral director John G. Miller
(b) Address 2384 Jefferson St.

19 (a) (b)
(Undertaker's address) Registrar

MAR 27 1947

To be signed by Medical Examiner

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25, 1947, at 8.55A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 24 1947 to March 25 1947 and that I last saw h[illegible] alive on March 25 1947.

Immediate cause of death Complete paralysis from cervical region down. — Duration 18 hrs

Due to Compression cervical cord

Due to Dislocation C5 on C6

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 2/24/47
Major findings of operation Application Centrafield tongs.
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 2/24/47 at 3:00 P.M.
(c) Where did injury occur Baltimore, Baltimore, Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Niece's home While at work? no (Specify type of place)
(e) Means of injury slipped on wet steps

23. Signature R. P. Gibbs
Address Baltimore City Hosp. Date signed 3/25/47 M. D.
For C. J. Zebinski
Howard J. Masters, M.D.

G50074

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G50074 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 120 S. Hilton St.
(c) Hospital or institution:
20
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 120 S. Hilton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Hawkins.

3 (b) If veteran, name war: None.

3 (c) Social Security Account No. 213-07-4114.

4 Sex: Male | 5. Color or race: White. | 6 (a) Single, married, widowed, or divorced: Single.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July-19-1875.

8. AGE: Years 71 | Months 8 | Days 6 | If less than one day hr. min.

9. Birthplace Fort Hays - Kansas.
(Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER
12. Name Wright T. Hawkins.
13. Birthplace New York.

MOTHER
14. Maiden Name Mary E. Blake.
15. Birthplace Ireland.

16 (a) Informant Mr. Joseph H. Hawkins.
(b) Address 120 S. Hilton St.

17 (a) Burial. (b) Date thereof March 28-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Trinity Lutheran Cem.
Location Baltimore - Md.

18 (a) Funeral director Charles L. Schwab.
(b) Address 3512 Frederick Ave.

19 (a) (Date rec'd by Registrar) MAR 27 1947 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March, 25- 1947 at 12:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 6 1947 to March 25 1947 and that I last saw him alive on March 25 1947

Immediate cause of death — Duration

Arteio - sclerotic heart — 3 mos.
Due to Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. M. Collins M. D.
Address 532 Frederick Date signed

Dr x 3/26/47

C50075

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 92A

Registered No. C50075

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 239 days
(e) Length of stay in Baltimore (yrs., mos., or days) 239 days

2. USUAL RESIDENCE OF DECEASED:
(a) State NJ (b) County
(c) City or town Port Norris
(If outside city or town limits, write RURAL and give town)
(d) Street No. --
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Brown, Hezekiah

3 (b) If veteran, name war: --

3 (c) Social Security Account No. 145-16-4561

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	col	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1, 1901

8. AGE: Years	Months	Days	If less than one day
45	6	24	hr. min.

9. Birthplace Churchston, Md.
(Town, county, and state)

10. Usual Occupation AB seaman

11. Industry or business Seafarer

FATHER
12. Name Charles Brown
13. Birthplace Md.

MOTHER
14. Maiden Name Stas Matthews
15. Birthplace Md.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/47 (month) (day) (year)
(c) Cemetery or crematory Florence, Brown
Location Churchston, Md.

18 (a) Funeral director T. A Hardesty & Son
(b) Address Salisbury, Md.

19 (a) (Date received by local registrar) MAR 27 1947 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 19 47 at 8:58 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 29 19 46 to Mar. 25 19 47 and that I last saw him alive on Mar. 25 19 47.

Immediate cause of death Insufficiency of the aortic valve — Duration UNKNOWN

Due to Other conditions: Generalized anasarca — Duration SEVERAL MONTHS

Due to — Duration UNKNOWN

Other Conditions Myocardial hypertrophy
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 3/28/47

X

G50076

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No. G50076

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 33
(e) Length of stay in Baltimore (yrs., mos., or days) 39-10-1

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County Baltimore
(c) City or town BALTIMORE 12
(If outside city or town limits, write RURAL and give town)
(d) Street No. 911 QUEEN BROOK RD (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HELEN P. ANDREWS

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	MARRIED

6 (b) Name of husband or wife JOHN QUINCY ANDREWS
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) MAY 24, 1907

8. AGE: Years	Months	Days	If less than one day
39	10	1	hr. min.

9. Birthplace BALTIMORE MARYLAND (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name EDWARD H. POWELL
13. Birthplace VIRGINIA

MOTHER
14. Maiden Name CARRIE JAMES
15. Birthplace MARYLAND

16 (a) Informant HOSPITAL RECORDS
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director John J. Nolan
(b) Address 4421 Fremont Ave

19 MAR 27 1947 (Date rec'd by registrar) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 25 1947, at 10:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from MARCH 2 1947, to MARCH 25 1947, and that I last saw HER alive on MARCH 25 1947.

Immediate cause of death	Duration
ACUTE LEUKEMIA	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Evan R. Chamberlain M. D.
Address Union Memorial Hosp Date signed 3/25/47
534 Calvert + 515, Balto 18

VS 150

G50077

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G50077

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 706 Northern Parkway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 706 Northern Parkway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa Leimkuhler

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Edward Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 6 - 1860

8. AGE: Years 87 | Months 1 | Days 20 | If less than one day hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name William Heine
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Baumgarten
15. Birthplace Germany

16 (a) Informant Wm. J. Leimkuhler
(b) Address 706 Northern Pkwy

17 (a) Burial (b) Date thereof 3-29-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Rood
Location Belair Rd

18 (a) Funeral director John J. Madigan
(b) Address 2500 E. Balto. St.

19 (a) MAR 27 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 26 1947 at 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 9 1947, to March 26 1947, and that I last saw h[illegible] alive on March 24 1947.

Immediate cause of death	Duration
Hypertensive Cardio-Vascular Disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Wm J Schmick
Address 701 N. Ramsay St. Date signed 3/28/47
M. D.

V S 150

G50078

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 463

Registered No. G50078

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2512 W. LANVALE ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) LIFETIME

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2512 W. LANVALE ST. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JEANNETTE MIELCKE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOWED

6 (b) Name of husband or wife J. DAVID MIELCKE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 18, 1862

8. AGE: Years	Months	Days	If less than one day
84	11	7	hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER 12. Name FREDERICK BECK
13. Birthplace GERMANY

MOTHER 14. Maiden Name JEANETTE KASSE
15. Birthplace GERMANY

16 (a) Informant ADELE MIELCKE
(b) Address 2512 W. LANVALE ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3 27 47 (month) (day) (year)
(c) Cemetery or crematory LORRAINE
Location BALTIMORE

18 (a) Funeral director GEORGE WEBER & SON
(b) Address 2503 EDMONDSON AVE

19 (a) [illegible] (b) Huntington Williams, M.D.
MAR 27 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1947, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1946 to Mar. 25 1947 and that I last saw h[illegible] alive on March 24 1947

Immediate cause of death

	Duration
Carcinoma of Stomach	1 yr
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Norman A. Todd M.D.
Address 2108 St Paul St Date signed 3/26/47

VS 150

FORM: WRITE LEGIBLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JL -G 108249

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 6088

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1086 W. Lexington St.
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Boyd McClendon McClendon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1896 ?

8. AGE: Years	Months	Days	If less than one day
51 BOY	?	?	hr. min.

9. Birthplace S. C. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace S. C.

MOTHER
14. Maiden Name ?
15. Birthplace S. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 28 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) (b) Huntington Hollins (Registrar)

MAR 27 1947

MEDICAL CERTIFICATION 11:10 P.M.

20. DATE OF DEATH March (28) 24th 1947 (12:30) M

21. I certify that death occurred on the date above stated; that I attended deceased from March 22, 1947, to Mar. (28) 24 1947, and that I last saw him alive on March (28) 24, 1947

Immediate cause of death	Duration
Hemiplegia of unknown etiology	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. Russell Huff Jameson M. D.
Address Baltimore City Hosp. Date signed 26 Mar 47

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G50030 G50030 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 307 Myrtle Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph E. Smith.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: C

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Eliza Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1883

8. AGE: Years 65 | Months 1 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER 12. Name Joseph Smith
13. Birthplace

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. Eliza Smith.
(b) Address 307 Myrtle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 28 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mr. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/24 1947 at 6:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/24 1947 to 3/25/47 1947, and that I last saw h[illegible] alive on 3/25/47 1947.

Immediate cause of death My & Carcinoma — Duration

Due to Uremia & Pneumonia

Due to Senile Psy.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter T. Somers M.D.

Address 402 Edmondson Date signed 3/26/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

MAR 27

Huntington Williams, M.D.

X

G50031

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33a

Registered No. G50031

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1311 Bayard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1311 Bayard
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH NEWMAN

3 (b) If veteran, name war: N

3 (c) Social Security Account No. No

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Henry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/10/1902

8. AGE: Years 44 | Months 10 | Days 13 | If less than one day ..... hr. ..... min.

9. Birthplace A.A.County Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Wilson Butler
13. Birthplace A.A.County, Md.

MOTHER
14. Maiden Name Caroline
15. Birthplace A.A.County Md.

16 (a) Informant Marie Jenkins(D)
(b) Address 1311 Bayard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 Carrollton Ave

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

MAR 27 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/23/47 19..., at 11.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-16- 1947 to 3-23- 1947 and that I last saw h. lm alive on 3-23-1947.

Immediate cause of death Bronchopneumonia — Duration 4 days

Due to influenza — 1 wks

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature John Ed. L. Cooper M. D.
Address 623 N. Carey Date signed 3-27-47

X

correct age is especially important. Physicians: please write the ... IN ... INK. EVERY ITEM of information should be carefully supplied. The ... the causes of death clearly and legibly.

G50083

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 50083

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 598 1/2 Preston St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 598 1/2 Preston St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs Willie Diggs

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Nettie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/1/1886

8. AGE: Years 60 | Months 10 | Days 23 | If less than one day ....hr. ....min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER
12. Name John Diggs
13. Birthplace Md

MOTHER
14. Maiden Name S. Turner
15. Birthplace Md

16 (a) Informant Nettie M. Diggs
(b) Address 598 1/2 Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/28/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. G. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) Huntington Williams M.D. (Date received by registrar) (Registrar)

MAR 27 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/24 1947, at 6P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/21 1947 to 3/24 1947.
and that I last saw h[illegible] alive on 3/24 1947

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to: Paralysis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 3/25/47

G50083

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1638

G50033 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 13-
(c) Hospital or institution: West Baltimore General Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 3819 Falls Road. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Daniel S ~~David~~ Burke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lucy F Burke
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6, 1889

8. AGE: Years	Months	Days	If less than one day
57	9	20	hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business Rit Vernon Mills

FATHER
12. Name James F Burke
13. Birthplace Va

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Lucy F. Burke
(b) Address 3819 Falls Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 27 47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location

18 (a) Funeral director Chenoweth & Donovan.
(b) Address 3445-47 Eastern Ave.

MAR 27 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26, 1947, at 9.20 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Poisoning (barbiturate)
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/26/47 at 8 P. M.
(b) Where did injury occur? 3819 Falls Rd
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Ingestion of Barbiturates

23. Signature [signature] M.D. Medical Examiner.
Date signed 3/27/47

VS 191

Correct age if especially important. Physicians: please write the causes of death clearly and legibly.

G50031

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

G50034 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves.
(c) Hospital or institution: St. Agnes Hospital 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. St. Mary's Ind. School
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME BROTHER EDMUND Mc CONNELL C.F.X (EDWARD T. McCONNELL)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-27-93

8. AGE: Years 53 | Months 4 | Days 29 | If less than one day hr. min.

9. Birthplace Massachusetts (Town, county, and state)

10. Usual Occupation Religious

11. Industry or business

FATHER
12. Name Felix McConnell
13. Birthplace New York

MOTHER
14. Maiden Name Josephine Ladue
15. Birthplace Mass.

16 (a) Informant BROTHER ROGER C.F.X
(b) Address ST. MARY'S INDUSTRIAL SCHOOL

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof MAR. 28-1947 (month) (day) (year)
(c) Cemetery or crematory ST. JOHN'S PREPARATORY SCHOOL
Location DANVERS MASS.

18 (a) Funeral director Chas. J. Eggan Son Inc.
(b) Address 46 N. Mt. Royal Ave.

19 (a) MAR 27 1947 (Date rec'd by registrar) (b) Interior Baltimore Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1947 3:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-10 1947 to 3-26 1947 and that I last saw him alive on 3-26 1947.

Immediate cause of death	Duration
Cardio failure	
Cerebral embolism	
Hypertension Arteriosclerosis	
Due to Pneumonia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address St Agnes Date signed 3/26/47 M. D.

VS 150

PRESS WHITE PRINT, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50085

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G50085 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2912 Winchester street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 65 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ----
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2912 Winchester street (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN W. CASEY

3 (b) If veteran, name war ----
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Widower

6 (b) Name of husband or wife Catherine Casey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1866

8. AGE: Years	Months	Days	If less than one day
80	10	10	hr. min.

9. Birthplace Cork, Ireland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Cornelius Casey
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Ann Toomey
15. Birthplace Ireland

16 (a) Informant Mrs. Harry C. Jenkins
(b) Address 2912 Winchester street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick road

18 (a) Funeral director Chas. J. Evans & Son Inc
(b) Address 118 N. Mt. Royal Ave

19 (a) MAR 27 1947 (Date rec'd by registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1947, at 9.20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1945, to March 25 1947 and that I last saw him alive on March 25 1947

Immediate cause of death	Duration
uraemia	1 day
Due to Chr. nephritis	1 year
Due to arteriosclerosis	2 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. Fox Dermott M. D.
Address 1136 Poplar Grove St Date signed 3/26/47

VS 150

650086

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

150c

Registered No. [illegible]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette and Calhoun Sts.
(c) Hospital or institution: Franklin Square Hospital 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County B
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4118 W. Baltimore
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel M. Dunn

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-22-1803

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Edward J. Dunn
6 (c) If alive, give age 24 years

7. Birth date of deceased (mo., day, yr.) Nov 30 1927

8. AGE: Years	Months	Days	If less than one day
19	3	26	hr. min.

9. Birthplace Balto Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Robt A. Kinsey
13. Birthplace Balto Md

MOTHER
14. Maiden Name Catherine C. Wolf
15. Birthplace Balto Md

16 (a) Informant Catherine C. Kinsey
(b) Address 1625 W. Pratt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 31-1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto Md

18 (a) Funeral director Robt C. & B. M. Watters
(b) Address Pratt & Stricker St.

19 (a) [illegible] (Date received by registrar) [illegible] (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/26 1947, at 7.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw HER alive on 3/26 1947

Immediate cause of death	Duration
TOXIC ENCEPHALOPATHY	3 days
Due to CAUSE UNKNOWN	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy: NO - POST

PHYSICIAN
Underline the cause to which death should be charged statistically:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. Morton Hoff
Address 7. Eutaw Pl Date signed 3/26/47

VS 150

Birth Certificate G-74319 G50087

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 158

Registered No. G50087

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette Mahlman Sts.
(c) Hospital or institution Franklin Square Hosp. 2

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22hrs (22 min)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Motorist residence
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4119 W Baltimore Court
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Dunn (Ernest J. Dunn Jr)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-25-47

8. AGE: Years	Months	Days	If less than one day
			22 hr. 22 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Ernest J. Dunn
13. Birthplace Balto Maryland

MOTHER
14. Maiden Name Ethel M. KINSEY
15. Birthplace Balto Maryland

16 (a) Informant Catherine C. Kinsey
(b) Address 1625 W. Pratt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 31 1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto Md

18 (a) Funeral director Roth & B. M. Walters
(b) Address Pratt & Eutaw Sts

19 (a) 1947 (Date rec'd by registrar) (b) [illegible] Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26, 1947, at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death: Respiratory failure — Duration

Due to Cause unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Gordon Frantz M. D.
Address 7 E. Fayette Date signed 3/26/47

VS 150

G50088

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

B24 F 44690 / 170 C

G50088

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dor
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 503 Burgundy street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jerome Reynolds

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 18-1942

8. AGE: Years	Months	Days	If less than one day
5	2	7	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation none-

11. Industry or business

FATHER
12. Name Howard Reynolds.
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Louzia Wagley
15. Birthplace Balto. Md.

16 (a) Informant Louzia Reynolds
(b) Address 503 Burgundy St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 3-30-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calary.
Location Balto.

18 (a) Funeral director Walter B. Foreman
(b) Address 139 W. Hamburg Street

27 1947 (Date rec'd by registrar) (b) Registrar Langston Williams M.D.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26, 1947, at 2 45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence examined Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/26/47 2 35 P 22/2 M.
(b) Where did injury occur? In front of 526 Pacific St
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by truck

23. Signature Earl L. Royer M.D. Medical Examiner.
Date signed

Type or use ink and write the causes of death clearly and legibly. Items are especially important. Physicians: please write the

G50089 BALTIMORE CITY HEALTH DEPARTMENT G50089
CERTIFICATE OF DEATH 1312 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 207 S. Madeira St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 207 S. Madeira St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Berdyck
3 (b) If veteran, name war
3 (c) Social Security Account No. 213673623

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Marie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years 48 | Months — | Days — | If less than one day hr. min.

9. Birthplace Baltimore (town, county, and state)
10. Usual Occupation Steel Worker
11. Industry or business Beth. Steel Co.

FATHER 12. Name Frank Berdyck
13. Birthplace Poland

MOTHER 14. Maiden Name Agnes Szajda
15. Birthplace Poland

16 (a) Informant Marie Berdyck
(b) Address 207 S. Madeira St

17 Burial (Burial, cremation, or removal) (b) Date thereof Mch 29 '47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Orzazewski
(b) Address 1900 Eastern Ave

19 (a) 1947 (Date received by registrar) (b) Registrar's signature

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from January 24 1947, to March 26 1947 and that I last saw him alive on 19

Immediate cause of death	Duration
Valvular Heart Disease	
Chronic Nephritis	
Due to	
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation
of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury None
23. Signature Samuel Silverstein M. D.
Address 22 S. Broadway Date signed 3/27/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G50090 509993.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

G50090 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baroline
(c) City or town Federalsburg.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Irving Brummell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black.	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-12-47

8. AGE: Years	Months	Days	If less than one day
	1	13	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER — 12. Name Irving Mosea.
13. Birthplace Jamaica.

MOTHER — 14. Maiden Name Edna Brummell
15. Birthplace Md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/27/47 (month) (day) (year)
(c) Cemetery or crematory
Location Bridgeville Del.

18 (a) Funeral director E. J. Trunton & Son
(b) Address Federalsburg Md.

19 MAR 27 1947 (a) (Registrar) (b) Lington Williams (Deputy Registrar)

MEDICAL CERTIFICATION L

20. DATE OF DEATH March 25 1947, at 11.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mch. 13 1947, to Mch. 25 1947, and that I last saw him alive on Mch. 25 1947.

Immediate cause of death	Duration
(a) Cardiac failure	
Due to (b) Prematurity	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard E. Dorsett, M.D.
Address Johns Hopkins Hosp. Date signed 3/27/47 M. D.

VS 150

X

G50091

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G50091 Registered No.

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1404 Eutaw Place
(c) Hospital or institution: 14-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1404 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES JAMISON STEWART

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Rhoda Revell Stewart
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept. 27, 1856

8. AGE: Years	Months	Days	If less than one day
90	5	29	hr. min.

9. Birthplace: A. A. Co.
(Town, county, and state)
10. Usual Occupation: Real Estate - Retired
11. Industry or business: E. J. W. Revell

FATHER
12. Name: Charles R. Stewart
13. Birthplace: Md.

MOTHER
14. Maiden Name: Virginia Jamison
15. Birthplace: Md.

16 (a) Informant: Miss Virginia Stewart
(b) Address: 1404 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/28/47 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 27 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26, 1947, at 8:15a M

21. I certify that death occurred on the date above stated; that I attended deceased from March 17 1947, to March 26 1947, and that I last saw him alive on March 26th 1947.

Immediate cause of death	Duration
Cardiac Asthenia	2 days
Due to Pneumonia Lobar	7 days
Due to Arterial Sclerosis	10 yrs.
Other Conditions Stroke Right Side Paralysis	2 years

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence — at M
(c) Where did injury occur? no
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? No While at work?
(Specify type of place)
(e) Means of injury
23. Signature Herbert F. Zeppe M.D.
Address 3400 Hunden Rd Date signed 3/27/47

Hunting for Hotel
Baltimore 16
Maryland

G50092 Bk# B 39856 C-50092

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 1061 B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 3
(e) Length of stay in Baltimore (yrs., mos., or days) 15 Mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County -------
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2606 Talbot Rd.
(If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME William Earle Merriken

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife ----------
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) JAN. 2, 1946

8. AGE: Years	Months	Days	If less than one day
1	2/15	24	..... hr. ..... min.

9. Birthplace Balto
(Town, county, and state)
10. Usual Occupation ---------
11. Industry or business ----------

FATHER
12. Name Harry Merriken
13. Birthplace Oakland Md

MOTHER
14. Maiden Name Mary Schuttler
15. Birthplace Balt. Md.

16 (a) Interment Hospital Record
(b) Address

17 (a) Burial (b) Date thereof 3/28/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director No. W. Mears & Son
(b) Address 805 N. Calvert Street
Upontag for Williams, Md

MAR 27 1947 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/26 1947 at 11 40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/26 1947 to 3/26 1947 and that I last saw h[illegible] alive on 3/26/1947

Immediate cause of death	Duration
Cardiac Failure	
Due to ?	
Due to	over
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold M. Gillis Jr. M.D.
Address Mercy Hospital Date signed 3/26/47

VS 150

C.0033

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

C.0033

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 843 N. Durham St
(If rural give location)
(e) Citizen of foreign country? .....(Yes or No)
If yes, name country .....

3 (a) FULL NAME Michael Holle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Josephine Holle

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 8 1866

8. AGE: Years	Months	Days	If less than one day
70			..... hr. ..... min.

9. Birthplace Austria
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Andrew Holle
13. Birthplace Austria

MOTHER
14. Maiden Name Barbara Minja
15. Birthplace Austria

16 (a) Informant Jennie Holle
(b) Address 843 N. Durham St

17 (a) Burial (b) Date thereof 3-28-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Mark Brockson Son
(b) Address 700 N Chester St

MAR 27 1947 (a) ..... (b) .....
(Date received by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/25 1947, at 9:45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. disease

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature C. P. Sukman M.D.
Medical Examiner.
Date signed 3/26/47

Persons age is especially important. Physicians: please write the causes of death clearly and legibly.

X

G50094

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164a

G50094
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Days
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Pikesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 303 Church Lane
(If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Andrew Fisher Crofton

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 216-03-0064

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Evelyn O. Crofton
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Feb. 21 - 1901

8. AGE: Years	Months	Days	If less than one day
46	1	4	.....hr. .....min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Tool maker
11. Industry or business Westinghouse

FATHER
12. Name William Emory Crofton
13. Birthplace Virginia

MOTHER
14. Maiden Name Cinderalla Tallant
15. Birthplace Virginia

16 (a) Informant Evelyn O. Crofton
(b) Address 303 Church Lane, Pikesville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/28/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Frank H. Yewell
(b) Address Pikesville, Maryland

19 (a) MAR 27 1947 (Date rec'd by registrar) (b) Pikesville, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1947, at 12 Noon

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation by hanging

Due to.....

Other Conditions Pulmonary edema

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-26-47 at 2:15 P.M.
(b) Where did injury occur? 303 Church Lane
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Strangulation by hanging

23. Signature Earl L. Rogers M.D.
Medical Examiner.
Date signed 3-26-47

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50095 G50095

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 122a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Franklin Square Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Sykesville (If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3 (a) FULL NAME Claude Ridgley

3 (b) If veteran, name war.....

3 (c) Social Security Account No.....

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Lillie Ridgley

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 7th 1885

8. AGE: Years 61 | Months 8 | Days 19 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business.....

FATHER
12. Name Zazua Taylor
13. Birthplace Maryland

MOTHER
14. Maiden Name Mollie Cross
15. Birthplace Maryland

16 (a) Informant Records
(b) Address Franklin Square Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/47 (month) (day) (year)
(c) Cemetery or crematory St. Johns
Location Ellicott City Md

18 (a) Funeral director C. Harry Weer
(b) Address Sykesville Md.

MAR 28 1947 Huntington Williams M.D. Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

28. DATE OF DEATH March 26 1947, at 1 25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-9-47 1947 to 3-26 1947, and that I last saw him alive on 3-26 1947

Immediate cause of death
Pulmonary Embolism — Duration 1½ hrs.
Post operative Bilateral — 17 days
Due to Hernia Incarcerated Acute — 2 days
Due to Uremia Atonic + Pneumonia Bilateral Lung — 3 days

Other Conditions Hernia
(Include pregnancy within 3 months of death)

Date of operation 3-10-47

Major findings of operation —

of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at ..... M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury.....

23. Signature Stanley B. Klymowicz M.D.
Address Crumbaker Bldg Hyattsville Md Date signed 3-26-47

50096

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G50096 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1810 Ramsay St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1810 Ramsay St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Rose Marie Yeager

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: John Adam Yeager
6 (c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Sept. 14, 1868

8. AGE: Years 78 | Months 6 | Days 12 | If less than one day: hr. min.

9. Birthplace: Germany (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name ? Rebmann
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant: Catherine Yeager
(b) Address 1810 Ramsay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-29-47 (month) (day) (year)
(c) Cemetery or crematory: Western
Location: Baltimore, Md.

18 (a) Funeral director: George L. Sehrel
(b) Address 2101 Frederick Ave.

19 (a) [illegible] (Registrar) Hunting for Williams M.D.

MAR 28 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1947 at 1:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/20 1947 to 3/26 1947 and that I last saw her alive on 3/26 1947.

Immediate cause of death: Arteriosclerosis — Cardiac vascular disease — Duration: 6 mos.
Due to: Cerebral hemorrhage — 5 days
Due to:
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Benjamin Miller M. D.
Address 2630 Wilkens ave Date signed 3/26/47

C-50097

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. C-50097

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1727 Abbottston st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1727 Abbottston st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John E. Stallings

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-14-5592

4. Sex: Male | 5. Color or race: White | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of ~~husband or~~ wife: Sara V. Stallings

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 14th 1871

8. AGE: Years: 75 | Months: 7 | Days: 12 | If less than one day: hr. min.

9. Birthplace: Balto. Co. Md.
(Town, county, and state)

10. Usual Occupation: Retired Engineer

11. Industry or business: Grundel Sand & Gravel Co

FATHER 12. Name: Richard Stallings

13. Birthplace: Md.

MOTHER 14. Maiden Name: Caroline Greenhimer

15. Birthplace: Balto. Co. Md.

16 (a) Informant: John Stallings

(b) Address: 1660 Gorsuch Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/47 (month) (day) (year)

(c) Cemetery or crematory: Holy Redeemer

Location: Balto. Md.

18 (a) Funeral director: William Cook Inc.

(b) Address: 1217 St. Paul st.

19 (Date received by registrar) MAR 28 1947 (Signature of registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 26th 1947 at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/11th 1946 to 3/24th 1947 and that I last saw h.. alive on 3/24th 1947

Immediate cause of death	Duration
Pulmonary Edema	
Due to Cardio Renal Disease	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H J Faulkner

Address 1001 Hollins Date signed 3/27/47 M. D.

VS 150

X

...ORMS WHITE PRINTING, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No. G50098

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 653 N. Bartelow St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 11 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 653 N. Bartelow St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME CLARA CATHERINE Beamer.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife: Ferdinand W. Beamer
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) October 24 - 1868

8. AGE: Years 78 | Months 5 | Days 2 | If less than one day ____ hr. ____ min.

9. Birthplace Oceanville - New Jersey
(Town, county, and state)

10. Usual Occupation none
11. Industry or business —

FATHER
12. Name Eben Somers.
13. Birthplace New Jersey.

MOTHER
14. Maiden Name Hester Dougherty
15. Birthplace New Jersey.

16 (a) Informant Clara B Moore
(b) Address 653 N. Bartelow St.

17 (a) Burial (b) Date thereof 3/29/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location " Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) MAR 29 1947 Huntington Williams, M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 — 1947, at 1:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from February 2 1947, to March 26-1947, and that I last saw h.er. alive on March 24 1947.

	Duration
Immediate cause of death: Organic Heart disease	
Due to: Influenza	8 da.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature Chester Roland M.D.
Address 2532 Edmondson Ave Date signed 3-26-47

M. D.

PRINT ALL ENTRIES, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50099

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

Registered No. G50099

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 219 S. Monroe St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Athera Sunday

3 (b) If veteran, name war: W
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, ~~widowed, or~~ divorced. Married
6 (b) Name of husband ~~or wife~~: Charles Sunday
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Mar. 4th 1907
8. AGE: Years 40 | Months 0 | Days 23 | If less than one day hr. min.
9. Birthplace Greece (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Dimitri (Unknown)
13. Birthplace Greece

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Charles Sunday
(b) Address 219 S. Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Greek Community
Location Windsor Mill Rd. Woodlawn Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) MAR 28 1947 (Date received by registrar) (b) Washington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1947 at 2:50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/4 1947 to 3/27 1947 and that I last saw h[illegible] alive on 3/27 1947

Immediate cause of death: Pneumonia - Postop

	Duration
Due to	
Due to	
Other Conditions: Subglutenic Abscess Duodenal Fistula	

(Include pregnancy within 3 months of death)

Date of operation 3/22/47

Major findings of operation: Duodenal fistula + Subglutenic abscess

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel D. Gabay M. D.
Address Sinai Hospital Date signed 3/27/47

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50100

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1110 B

Registered No. G50100

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calhoun & Fayette
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 401 S. Leigh St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Ralph Lee Mobley (MOBLEY) Sr.
3 (b) If veteran, name war (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, (widowed) or divorced.
M	W	

6 (b) Name of husband or wife Marie Mobley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 26th 1884

8. AGE: Years	Months	Days	If less than one day
62	5	29	hr. min.

9. Birthplace Savannah Ga. (Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business Crown Cork-Seal Co.

FATHER
12. Name Hendley W. Mobley
13. Birthplace Ga.

MOTHER
14. Maiden Name Harriett Foster
15. Birthplace Ga.

16 (a) Informant Mrs Purvis
(b) Address 54 E. 32nd St.

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 3/31/47 (month) (day) (year)
(c) Cemetery or crematory Balto.
Location " Md.

18 (a) Funeral director William Cook Inc
(b) Address 217 St Paul St.

MAR 28 1947 (Date received by registrar) Harrington for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-25- 1947 at 10 30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-23 1947 to 3-25 1947, and that I last saw him alive on 3-25 1947

	Duration
Immediate cause of death Myocardial failure	3 da.
Due to Pneumothorax, left	3 da.
Due to Rupture of emphysematous air sac	3 da.
Other Conditions Haemothorax	3 da.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robt. B. Knight M. D.
Address Franklin Square Hosp. Date signed 3-25-47
1 Medical Arts Bldg.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G5101

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BC# B 55666 / 119a

Registered No. G5101

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3713 9th st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3713 9th St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Phyllis M Todd.

3 (b) If veteran, name war No | 3 (c) Social Security Account No. No

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT 5 1946

8. AGE: Years | Months: 6 | Days: 22 | If less than one day: hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER: 12. Name Omer L Todd
13. Birthplace Va (Harrisonburg)

MOTHER: 14. Maiden Name Lena Broaden
15. Birthplace Balto Md

16 (a) Informant Omer L. Todd (Father)
(b) Address 3713 9th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A.A. Co. Md.

18 (a) Funeral director Wilkins Cook Inc.
(b) Address 127 St Paul St

MAR 28 1947 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 27 1947, at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 24 1947 to Mar 27 1947, and that I last saw h[illegible] alive on Mar 26 1947.

Immediate cause of death acute cardiac failure -
Due to diarrhea (nurse)
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature P. M. Kirsch MD
Address 302 Patapsco Ave Date signed 3/27/47

VS 150

X

POUND WHITE PAPER, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G:0:02

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G:0:02

THIS CERTIFICATE MUST BE TYPEWRITTEN OR WRITTEN WITH INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 408 N. Linwood Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 408 N. Linwood Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bernard Burns, Sr.

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 220-05-4802

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife: Anna M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27, 1871

8. AGE: Years	Months	Days	If less than one day
75	7	29	hr. min.

9. Birthplace York, Pennsylvania (Town, county, and state)
10. Usual Occupation Iron Molder
11. Industry or business

FATHER
12. Name John Burns
13. Birthplace ?

MOTHER
14. Maiden Name Margaret Christine
15. Birthplace Pennsylvania

16 (a) Informant Anna M. Burns
(b) Address 408 N. Linwood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/47 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location York, Pennsylvania

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

MAR 28 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26, 1947, at 8 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-4 1947 to 3-26 1947, and that I last saw h alive on 3-25 - 1947.

Immediate cause of death	Duration
Acute Congestive Cardiac Failure	1 week
Due to Myocardosis	?
Due to Arteriosclerotic Heart Disease	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Francis J. Januszeski, M. D.
Address 540 N. Lincoln Rd Date signed 3/27/47

VS 150

G5 D103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G5 D103

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Reisterstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. Nicodemus Road
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3 (a) FULL NAME Jacob Nees

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 218-18-2607A

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: W.

6 (b) Name of husband or wife: Lucy Agnes Nees
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 9-27-76

8. AGE: Years 70 | Months 5 | Days 29 | If less than one day ____ hr. ____ min.

9. Birthplace Prussia
(Town, county, and state)

10. Usual Occupation Farmer
11. Industry or business —

FATHER 12. Name Samuel Nees
13. Birthplace Prussia

MOTHER 14. Maiden Name Sarah [illegible]
15. Birthplace Prussia

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Mar 29-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Pleasant Grove Cemetery
Location Boring Md

18 (a) Funeral director Wm. Berryman & Sons
(b) Address Reisterstown Md

19 MAR 28 1947 (b) Huntington Williams M.D.
(Registrar) (Deputy)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-26-47, 19__, at 6.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from on 3/26 1947, to ____ 19__, and that I last saw him alive on 3-26 1947.

Immediate cause of death: Heart failure
secondary to Coronary
Thrombosis — Duration

Due to

Due to

Other Conditions: Benign prostatic hypertrophy
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Pete L. Scarfo M. D.
Address Johns Hopkins Hospital Date signed 3-27-47

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C:D:104

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

C:D:104 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hosp. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) Don
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1325 Woodyear Ave (If rural give location) 2 mi ft
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sage Albert Carr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	married

6 (b) Name of husband or wife Rosie P. Carr

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) aug 2, 1889

8. AGE: Years	Months	Days	If less than one day
57	7	24	hr. min.

9. Birthplace md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name —
13. Birthplace md

MOTHER
14. Maiden Name Joanna Smith
15. Birthplace md

16 (a) Informant Dorothy C. Fletcher
(b) Address 1405 Presstman St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 3-29-47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location md

18 (a) Funeral director George S. Valsam
(b) Address 1303 Presstman St

MAR 28 1947 (Date received by registrar) Huntington Williams M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26, 1947 at 1 A. M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH 2nd and 3rd degree burns of entire body Shock

Other Conditions

(Include pregnancy within 3 months of death)

154

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/26/47 at 12 30 A. M.
(b) Where did injury occur? 1325 Woodyear Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Oil stove exploded

23. Signature Earl L. Kruger M.D. Medical Examiner.
Date signed

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G50105 G50105

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W. 40th St.
(c) Hospital or institution:
Home for Incurables
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5004 Belair Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Philip M. Malkus.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Lina Alland Malkus.

6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) 12-13-1887

8. AGE: Years 59 Months 3 Days 14 If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Organist

11. Industry or business

FATHER
12. Name Daniel Malkus
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Klerlein
15. Birthplace Germany

16 (a) Informant Home for Incurables A. Lake,
(b) Address 700 W. 40th St

17 (a) Burial (b) Date thereof 3/29/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location North Ave & Rose St.

18 (a) Funeral director Howard M. Blight, Jr.
(b) Address 4914 Belair Road

MAR 28 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27. 1947., at 12:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 1 1946. to March 27 1947. and that I last saw him alive on March 26 1947.

	Duration
Immediate cause of death: Cerebral Hemorrhage	2½ Hrs.
Due to: Arteriosclerosis (Hemorrhage)	5 Years
Due to: Hypertension (Essential)	12 years
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Grafton Hersperger M. D.
Address 214 Medical Arts Bldg. Date signed 3/27/47

VS 3

X

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G50106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G50106

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution University Hospital DOA 18

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 108 N Fremont Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Boyer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. Widower.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 60 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Boyer.
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Harold White
(b) Address 108 N. Fremont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 28 1947 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Schroeder St

19 (a) MAR 28 1947 (Date rec'd by registrar) (b) Katie R. Williams M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1947, at 10:00 M

21. I certify that I took charge of the remains described above, held an Autopsy Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio-Vascular disease.
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J Kelly M.D.
Medical Examiner.
Date signed March 26, 1947

X

C.D.07

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

C.D.07

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Fantyn Sts
(c) Hospital or institution: Mercy Hosp. 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1006 Druid Hill Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Jessie Posey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	B	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/11/1887

8. AGE: Years	Months	Days	one day
50	-	16	min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Peter Anderson
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Bruce
15. Birthplace Md

16 (a) Informant Gertrude Jackson
(b) Address 343 Preston St.

17 (a) Burial (b) Date thereof March 29 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (Filed) MAR 28 1947 (Signature of registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/27/1947, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/20 1947 to 3/27 1947 and that I last saw h[illegible] alive on 3/27 1947.

Immediate cause of death	Duration
Lung Embolism	
Due to Pneumonia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature August Kiel M. D.

Address Mercy Hosp Date signed 3/27/47

VS 150

0108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓167

Registered No. C-D-03

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 646 West Hoffman Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES (JACK) TANNER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21, 1901

8. AGE: Years	Months	Days	If less than one day
45 46	8	6	hr. min.

9. Birthplace Norfolk, Virginia
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Abraham Tanner
13. Birthplace Virginia

MOTHER
14. Maiden Name Josephine Smith
15. Birthplace Virginia

16 (a) Informant Josephine Tanner
(b) Address 646 W. Hoffman St

17 (a) Burial (b) Date thereof 3/31/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill & Md.

18 (a) Funeral director A. Sabatezz
(b) Address 916 Druid Hill Ave.

19 MAR 28 1941 (Date received by registrar) Quentin Tom Williams

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27, 1947, at 2.35 a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab wound of Heart

Due to

Other Conditions Multiple stab wounds face & Chest
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/27/47 at 1.10 a. M.
(b) Where did injury occur? 1111 Wilmer Court.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Sharp instrument

23. Signature Earl L Ryan M.D.
Medical Examiner.
Date signed 3-27-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C5C109

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C5C109 / 169

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Anne Arundel
(a) State Md. (b) County Greenhaven
(c) City or town Pasadena
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES L. KECK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Susie C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19-1898

8. AGE: Years	Months	Days	If less than one day
48	10	7	hr. min.

9. Birthplace Penna. (Town, county, and state)
10. Usual Occupation Stevedore
11. Industry or business R. C. Hendry & Bro.

FATHER
12. Name Thomas Keck
13. Birthplace Pa

MOTHER
14. Maiden Name Charlotte Prepler
15. Birthplace Pa.

16 (a) Informant Susie Keck - Wife
(b) Address Glen Haven - Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/31/47 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Ritchie Highway

18 (a) Funeral director Lilly & Zeckhauser
(b) Address 403 E. Lombard St.

MAR 28 1947 (Date received by registrar) Wellington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26, 1947, at 12.10 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Fractured skull; Crushed chest;
Ruptured pericardium; Hemo-thorax;
hemo-peritoneum; Fractured pelvis
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-26-47 at 11.45 a. 24 M.
(b) Where did injury occur? Pier #4 Locust Point.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Crushed between railroad car frames

23. Signature Howard J. Mellin M.D. Medical Examiner.
Date signed 3-27-47

VS 151

X

G50110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

G50110 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison St.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs. ~~mos.~~ or days) 39
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2744 St. Paul St. #18
(If rural give location)
(e) Citizen of foreign country? ~~Yes~~ (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Catherine Reuter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/28/64

8. AGE: Years	Months	Days	If less than one day
82 83	2	29	hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER 12. Name John Reuter
13. Birthplace ?

MOTHER 14. Maiden Name Graves ?
15. Birthplace ?

16 (a) Informant Mrs. Walter Curran
(b) Address 2744 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/31/47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location German Hill Road

18 (a) Funeral director Lilly & Lilly Inc
(b) Address 503 W. Lafayette St.

MAR 28 1947 (a) Date received by registrar (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/24 1947 at 1 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/15 1947 to 3/26 1947 and that I last saw h~~er~~ alive on 3/24 1947.

Immediate cause of death Hemorrhagic cardiovascular Collapse — Duration

Due to Hypertensive cardiovascular Renal disease

Due to Carcinoma of body of uterus

Other Conditions Fracture, simple, humerus, neurectomy, gallbladder, family (include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: Carcinoma of uterus

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John E. Muller M. D.
Address Maryland Gen'l Hosp. Date signed 3/28/47

VS 150

G5D11

510004

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G5D11

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3000 W. Garrison Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jack Katz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Rosie

6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) 7-3-96

8. AGE: Years	Months	Days	If less than one day
50	8	24	hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name ? ?

13. Birthplace Russia

MOTHER 14. Maiden Name Gertrude ?

15. Birthplace Russia

16 (a) Informant Rosalia

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-28-47 (month) (day) (year)

(c) Cemetery or crematory Loudale

Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc

(b) Address 1436 E Balto St

19 (a) Mar 28 1947 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH March 27 1947, at 4.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 14 1947, to March 27 1947 and that I last saw him alive on Mar 27 1947

Immediate cause of death	Duration
CARDIAC FAILURE	HOURS
Due to MYOCARDIAL INFARCTIONS MULTIPLE - OLD AND RECENT	(6 WKS AND 2 DAYS)
Due to	
Other Conditions GEN. ARTERIOSCLEROSIS	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: AS ABOVE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maxwell Williams M.D.

Address Johns Hopkins Hosp Date signed 3-29-47

G-50112

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered No. G-50112

Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly. USE BLACK OR BLUE INK. WITH UNFADING INK.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland 33rd & Calvert Sts

(b) Street address Union Memorial Hosp.

(c) Hospital or institution: Union Mem. Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days

(e) Length of stay in Baltimore (yrs., mos., or days) 66 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto.

(c) City or town Towson

(If outside city or town limits, write RURAL and give town)

(d) Street No. 624 Annaslie Rd.

(If rural give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3 (a) **FULL NAME** HARRY MANSFIELD MICHEL

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife PAULINE M. MICHEL

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB 17 1881

8. AGE: Years	Months	Days	If less than one day
66	1	10	hr. min.

9. Birthplace Baltimore Co., Md.
(Town, county, and state)

10. Usual Occupation Supt. Balto County Fire Bloomers

11. Industry or business

FATHER

12. Name JACOB MICHEL

13. Birthplace MARYLAND

MOTHER

14. Maiden Name ELIZA KLEINE

15. Birthplace MARYLAND

16 (a) Informant Mrs. Pauline M. Michel

(b) Address 624 Annaslie Rd., Towson, Md.

17 (a) Burial (b) Date thereof 3/31/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cem.

Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) Date received by registrar MAR 28 1947 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 27 1947, at 12 05 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 19 47 to March 27 1947, and that I last saw h[illegible] alive on March 26 19 47.

	Duration
Immediate cause of death Respiratory Failure	
Due to Arteriosclerotic Heart Disease	6 months
Due to	
Other Conditions Carcinoma Bladder	3 years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Joseph C. Price M. D.

Address Union Mem. Hosp. Date signed March 27, 1947

0113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 650113

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dod
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 142 N. Exeter Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lena Foreman

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widow

6 (b) Name of husband or wife Emil Foreman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1879

8. AGE: Years	Months	Days	If less than one day
67	3	0	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Sophie Vakoutis, daughter
(b) Address 1732 Thames St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/47 (month) (day) (year)
(c) Cemetery or crematory St. Peters Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 MAR 28 1941 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION 25

20. DATE OF DEATH March 25, 1947, at 8 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary disease, Chronic myocarditis, generalized
Due to Arteriosclerosis

Other Conditions Emphysema of left lung
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Worden M.D.
Medical Examiner.
Date signed 3/28/47

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BCHD 73317

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G.D. 114 / 160a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1111 Brewer St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Christine Gillyard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 13th 1947

8. AGE: Years | Months | Days: 11 10 | If less than one day: hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER
12. Name Henry Gillyard
13. Birthplace Hemingway South Carolina

MOTHER
14. Maiden Name Margret Jones
15. Birthplace Baltimore, Maryland

16 (a) Informant Lizinia Jones
(b) Address 1111 Brewer St, Balti.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/28/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemet.
Location Cedar Hill Md.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

MAR 28 1947 (Registrar's signature) Huntington for Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23rd 1947, at 7.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 21 1947 to March 23 1947, and that I last saw h. im alive on 3-23 1947

Immediate cause of death: Convulsions
Due to: probable tetanus neonatorum
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration: 1 week

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 718 Dolphin St. Date signed 3-27-47

G50115 Birth Certificate F-12745 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 182a Registered No. G-D115

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 401 S Conkling St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 401 S. Conkling St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ellen Ruth Berman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/8/47

8. AGE: Years	Months	Days	If less than one day
		21/20	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Ellis Berman
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Miriam Lobow
15. Birthplace Baltimore, Maryland

16 (a) Informant Ellis Berman
(b) Address 401 S. Conkling St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-28-47 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt. Carmel
Location Germany Hill Rd.

18 (a) Funeral director Jacob Lewis Inc
(b) Address 1434 E. Baltimore St.

MAR 28 1947 (Date registrar) Walter for Williamson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1947 at 7:00 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Mechanical Suffocation

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 2619
(a) Date of injury 3-21-47 at M.
(b) Where did injury occur? 401 S. Conkling St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Suffocation by bedclothes

23. Signature Edward L. Cowden M.D.
Medical Examiner.
Date signed 3-28-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 191

C50119 BALTIMORE CITY HEALTH DEPARTMENT C50116

BC# F99965 CERTIFICATE OF DEATH 108 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 222 S Broadway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 222 S Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dennis (Andrew) Carr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1944

8. AGE: Years	Months	Days	If less than one day
2	10	16 29	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name James Andrew Carr
13. Birthplace District, Pa.

MOTHER
14. Maiden Name Ruby L Truitt
15. Birthplace Washington D.C.

16 (a) Informant James A. Carr
(b) Address 222 S. Broadway

17 (a) Burial (b) Date thereof 3/28/1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St Mathias ?
Location Edmondson Ave

18 (a) Funeral director Wendel Chapel
(b) Address 312 S. Hopkins Place

19 (a) MAR 28 1947 (b) Huntingtown Williamsport Md
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1947, at 3:30 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia

Due to

Other Conditions Anemia

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury.

23. Signature Earl L Royer M.D.
Medical Examiner.
Date signed

VS 191

Birth Certificate

G-74443

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G50117

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1321 Patapsco Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BABY Baier

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 24, 1947

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Wm. Tyors
13. Birthplace N.Y. [illegible]

MOTHER
14. Maiden Name Mary Baier
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Mar. 28-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Grove Cem.
Location Eastern

18 (a) Funeral director John L. Miller
(b) Address 2334 Jefferson St.

19 (a) MAR 28 1947 Dr. Hattie Williams M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1947, at 10:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 24 1947, to Mar. 25 1947, and that I last saw him alive on Mar. 25 1947.

Immediate cause of death	Duration
Atelectasis, bilateral	
due to prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
Autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Russell Jordan M.D.
Address Johns Hopkins Hospital Date signed 3-28-47

VS 150

G-0118

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183

Registered No. G-0118

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State New Jersey (b) County
(c) City or town Newark
(If outside city or town limits, write RURAL and give town)
(d) Street No. 583 Springfield
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emil BENNES Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years 21 | Months | Days | If less than one day hr. min.

9. Birthplace ?
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name Emil Bennes Sr.
13. Birthplace ?

MOTHER
14. Maiden Name Freida Bennes
15. Birthplace ?

16 (a) Informant Emil Bennes Jr.
(b) Address Newark N. J.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/28/47 (month) (day) (year)
(c) Cemetery or crematory
Location Newark N.J.

18 (a) Funeral director Joseph Farace Inc.
(b) Address 203 Clinton St Newark

19 (a) MAR 28 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27th 1947 at 11 a.m.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Drowning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death fill in the following:
(a) Date of injury Found 3/27/47 at 9:15 a.m. 4/1
(b) Where did injury occur? Pier 5 - Hudson River
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Found Deceased

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 3/28/47

VS 181

Every age is responsibly important. Physicians: please write the causes of death clearly and legibly.

G50119
52311

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

54a

Registered No. G50119

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Canada (b) County
(c) City or town Regina Saskatchewan
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1700 College Ave.
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Canada

3 (a) FULL NAME ISAAC WALLWIN SNEATH

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Nellie Catherine Sneath
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-15-1882

8. AGE: Years	Months	Days	If less than one day
64	3	12	hr. min.

9. Birthplace Canada
(Town, county, and state)
10. Usual Occupation Physician
11. Industry or business

FATHER
12. Name ?, Sneath
13. Birthplace Canada

MOTHER
14. Maiden Name ?, ?
15. Birthplace Canada

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 3/29/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Regina, Saskatchewan, Canada

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) MAR 28 1947 (b)
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1947, at 5:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 25 1947, to March 27 1947, and that I last saw him alive on March 27 1947.

Immediate cause of death: Glioma of Brain

Due to

Due to

Other Conditions: Bronchopneumonia

Duration: 6 mos? / 24 hrs

(Include pregnancy within 3 months of death)
Date of operation: Mar 26, 1947
Major findings of operation: Subtotal Glioma of Brain
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arthur B Long
Address Johns Hopkins Hosp Date signed 3/29/47

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

050120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

63B

Registered No. 6-D120

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd St. & Guilford Ave.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos., or days~~) 9 DAYS
(e) Length of stay in Baltimore (yrs., ~~mos., or days~~) 76

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3621 Forest Park Ave.
(If rural-give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARY ELIZABETH COYLE

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife William F. Coyle, Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 19, 1875

8. AGE: Years	Months	Days	If less than one day
71	3	8	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name James E Joare
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name [illegible] McKenzie
15. Birthplace

16 (a) Informant Hospital Records
(b) Address 33rd St. & Guilford Ave.

17 (a) Burial (b) Date thereof 3/29/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 28 1947 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27, 1947, at 4:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 19, 1947, to March 27, 1947, and that I last saw h-er alive on March 27, 1947.

Immediate cause of death cerebral hemorrhage
Hypertensive cardiovascular disease

Due to ↓

Due to

Other Conditions Moderate Toxic Goiter

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

Duration 7

7

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. F. Howe M. D.
Address Union Mem. Hosp. Date signed 3/29/47

VS 150

Hosp X

C50121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C50121

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1059 Argyle Avenue
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME HETTIE [redacted] NICHOLS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17, 1887

8. AGE: Years	Months	Days	If less than one day
59	8	8	hr. min.

9. Birthplace Rockingham, N. C.
(Town, county, and state)

10. Usual Occupation.....
11. Industry or business

FATHER
12. Name.....
13. Birthplace

MOTHER
14. Maiden Name.....
15. Birthplace

16 (a) Informant Mrs. Manzah Little
(b) Address 1059 Argyle Ave.

17 (a) Burial (b) Date thereof March 25, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Family Lot
Location Rockingham, N. C.

18 (a) Funeral director Chas. Geo. W. Holland
(b) Address 1651 Pitcher St. Baltimore, Md.

19 (a) 3/28/47 (b) [redacted] Registrar
(Date received by registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25, 1947, at 1 P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH.....
Coronary thrombosis
Due to.....
Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?.....
(d) Means of injury.....

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 3-26-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Typed or PRINTED in PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 0122 TRUGLIO ✓ G50122

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Corner of Redwood + Greene St.
(c) Hospital or institution:
University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 610 W. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Truglio

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Rose M. Truglio
6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) March 6 1899

8. AGE: Years	Months	Days	If less than one day
48		20	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation
11. Industry or business Barber

FATHER
12. Name Ignatius Truglio
13. Birthplace Italy

MOTHER
14. Maiden Name Rose Angelly
15. Birthplace Italy

16 (a) Informant Rose M. Truglio
(b) Address 610 W. Balto St.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 3-29-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Ave

18 (a) Funeral director John B. Milby Inc
(b) Address 2432 E. Oliver St.

19 (a) MAR 29 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26, 1947 at 10 55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 19, 1947 to March 26, 1947 and that I last saw him alive on March 26 1947

Immediate cause of death	Duration
Coronary Thrombosis	
Due to	
Due to	
Other Conditions Uremia	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Bruzzi Hospital
Address Univ. Hospital Date signed 3-26-47

X

G50123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G50123

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland + Rayner Ave
(c) Hospital or institution:
West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2734 Prospect ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Plassil

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed or divorced. Married

6 (b) Name of husband or wife John Plassil
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 13 1881

8. AGE: Years 65 Months 6 Days 13 If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Arnold
13. Birthplace Md

MOTHER
14. Maiden Name Unknown
15. Birthplace Md

16 (a) Informant Mrs. Margaret Crayton
(b) Address 3023 Belmont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 29 1947 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location Dorsey Md

18 (a) Funeral director Harry W. Wiltse
(b) Address 419 Edmondson Ave

19 (a) MAR 28 1947 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-26 1947, at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-15 1946 to 3-26 1946, and that I last saw her alive on 3-26 1947.

Immediate cause of death	Duration
Overwhelming toxemia	
Due to Diabetic Gangrene Rt Lt Leg Amputated	
Due to Diabetes	
Other Conditions Lt Leg Amputated 8 months ago (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benjamin Berdenoky M.D.
Address West Balto Gen Hosp Date signed 3/26/47

Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

VS 150

G50124

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G50124 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.A.
(b) Street address 316 E 33rd St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 316 E 33rd St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Simon Kemp (Kate Kemp) D.S.M.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Simon Joseph Kemp

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 24, 1872

8. AGE: Years 75 | Months 1 | Days 2 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas R.H. Worthington
13. Birthplace Md

MOTHER
14. Maiden Name Alice Gosnell
15. Birthplace Md

16 (a) Informant Mrs alice F Kemp
(b) Address 316 E 33rd St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 29 '47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd

18 (a) Funeral director Harry A Stifler
(b) Address 401 Edmondson Ave

19 (a) MAR 28 1947 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/26 1947, at 3:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Sobenda M.D.
Medical Examiner.
Date signed 3/26/47

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G50125

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 757 Carroll St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 757 Carroll St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret C. Weishecker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W.	Married

6 (b) Name of husband or wife John F. Weishecker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 24, 1892

8. AGE: Years	Months	Days	If less than one day
54	11	2	hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation H.W.
11. Industry or business

FATHER 12. Name Charles F. Lang
13. Birthplace Balto. Md

MOTHER 14. Maiden Name Henrietta Huber
15. Birthplace Balto. Md.

16 (a) Informant John F. Weishecker
(b) Address 757 Carroll St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/47. (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location 3801 Frederick Rd.

18 (a) Funeral director Harry H. Leitzke
(b) Address 4101 E Monument Ave

19 (a) MAR 28 1947 (Date rec'd by registrar) (b) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/26/47. 19..., at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to 3-26 19 47 and that I last saw alive on 3-26 19 47

Immediate cause of death Carcinoma of Larynx — Duration

Due to —

Due to —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis J. Stone M.D.
Address 876 Wolfe St. Date signed

X 3/27/47

G50126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G 0126

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution:
University Hosp. 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 N. Bradford St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Martini

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 6th 1870

8. AGE: Years 76 | Months 4 | Days 21 | If less than one day hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Commission Merchant

11. Industry or business J. Talley & Co.

FATHER 12. Name Herman Martini

FATHER 13. Birthplace Germany

MOTHER 14. Maiden Name Katherine Hertsbacher

MOTHER 15. Birthplace Germany

16 (a) Informant Mrs. Talbott

(b) Address 1620 N. Bradford St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 31st 1947 (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location E. North Ave. Extd.

18 (a) Funeral director Leo E. Keogh

(b) Address 1201-03 N. Patterson Park Ave.

19 (a) MAR 28 1947 (Date rec'd by registrar) (b) Huntingtown Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 27, 1947, at 1:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 23 1947 to Mar 27 1947 and that I last saw him alive on Mar 26 1947.

Immediate cause of death Arteriosclerotic Cardiovascular Disease — Duration

Due to

Due to

Other Conditions Uremia

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles E. Hays M.D.

Address University Hospital Date signed Mar 27 47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G-50127

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G-50127

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Layer
(c) Hospital or institution:
West Baltimore Gen'l Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2908 W. Putty Hill Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rev. Bressler, Leroy

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-09-3509

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Penna (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name Edward R. Bressler
13. Birthplace Penna

MOTHER
14. Maiden Name Alice J. Sinerds
15. Birthplace Penna

16 (a) Informant Mrs. Margaret Bressler
(b) Address 2908 W. Putty Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 29 1947 (month) (day) (year)

(c) Cemetery or crematory Lutheran Reformed
Location Stiftz Penna

18 (a) Funeral director Leo G. Sofaer
(b) Address 1701-03 N. Patterson Park Ave.

19 (a) MAR 28 1947 (Date rec'd by registrar) (b) Harry [illegible] (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-26 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-26 1947 to 3-26 1947 and that I last saw h. M alive on 3-26 1947

Immediate cause of death: Bilateral Lobar Pneumonia — Duration

Due to: Emphysema

Due to: Chronic Heart Failure

Other Conditions: Pulmonary Edema
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address West Saltsdale Date signed 3/26/47

VS 150

650128
512440

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

157E

Registered No. 650128

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Wash. (b) County
(c) City or town Spokane (If outside city or town limits, write RURAL and give town)
(d) Street No. 1226 E. Sprague St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sylvia Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-24-44

8. AGE: Years 2 | Months 3 | Days 4 | If less than one day: hr. min.

9. Birthplace Washington State (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Stewart Smith

13. Birthplace U-W

MOTHER 14. Maiden Name Dorothy Larson

15. Birthplace Wash

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3-28-47 (month) (day) (year)

(c) Cemetery or crematory SPOKANE

Location WASHINGTON

18 (a) Funeral director John O Mitchell & Son

(b) Address 2900 Eastern Pl.

19 (a) MAR 28 1947 (Date filed by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 28, 1947 at 11 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 27 1947 to Mar 28 1947, and that I last saw h[illegible] alive on Mar 28 1947.

	Duration
Immediate cause of death Anoxia	15 min.
Due to Tetralogy of Fallot	Life
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 3/28/47

Major findings of operation: Pulmonary stenosis, absent right pulm. artery

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry B. Porter

Address Johns Hopkins Hosp Date signed 3/28/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

VS 150

Huntington [illegible]

X

G50129

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

Registered No. G50129

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Providence Hosp. 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dos
(e) Length of stay in Baltimore (yrs., mos., or days) 20yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1325 Woodyear St. (If rural give R.F.D. or near)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Eldridge

3 (b) If veteran, name war: No
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/14/15

8. AGE: Years 31 | Months 11 | Days 11/12 | If less than one day hr. min.

9. Birthplace Lynchburg Va. (Town, county, and state)

10. Usual Occupation Meat maker

11. Industry or business

FATHER 12. Name Chas Eldridge
13. Birthplace Va.

MOTHER 14. Maiden Name Frances Winn
15. Birthplace Va.

16 (a) Informant Frances Eldridge (M)
(b) Address 567 Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto Md

18 (a) Funeral director Chas H Orrison
(b) Address 517 Cancelstone

19 MAR 29 1947 (Date rec'd by registrar) (b) Huntington Williams (Registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26, 1947, at 1A M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereof and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH 2nd and 3rd degree burns of entire body burns with shock

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/26/47 at 12 30 P M
(b) Where did injury occur? 1325 Woodyear St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Oil stove Exploded

23. Signature [signature] M.D. (Medical Examiner.)
Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. The

G50130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G50130

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital 23 D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Houseboat-Foot of Dickman Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nora VICKERS

3 (b) If veteran, name war N

3 (c) Social Security Account No. NA

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband: Daniel Vickers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 6th 1877

8. AGE: Years 70 | Months 1 | Days 22 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Gable
13. Birthplace Un Known

MOTHER
14. Maiden Name "
15. Birthplace Eastern Shore of Md.

16 (a) Informant Daniel Vickers (Husband)
(b) Address Foot of Dickman st. Moles Point

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 31st 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

19 (Date rec'd by registrar) MAR 29 1947 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28, 1947 at 10.20 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cerebral hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 3/28/47

VS 181

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G50131

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 124 S. Patterson Park Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 124 S. Patterson Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida E. Byrd

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	2145

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife John W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 21, 1861

8. AGE: Years	Months	Days	If less than one day
85	5	6	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own Home

FATHER
12. Name John W. Roberts
13. Birthplace Maryland

MOTHER
14. Maiden Name Ann Jane Bartscher
15. Birthplace Maryland

16 (a) Informant Mrs. Charles Degenhard
(b) Address 3609 Old York Road

17 (a) Burial (b) Date thereof 3/31/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) MAR 29 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27, 1947, at 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to March 27 1947, and that I last saw her alive on March 27 1947.

	Duration
Immediate cause of death Coronary Thrombosis	3/27/47
Due to Arterio-Sclerosis Hypertension	10 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis F. Klemmens M.D.
Address 722 N. Kenwood Ave. Date signed 3/29/47

VS 150

G50132

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G50132

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution: Elmhurst Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) ?
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 46 E. West St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara C. Harding

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. NONE

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband: Marshall F. Harding
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 5th 1856

8. AGE: Years: 91 | Months: 2 | Days: 21 | If less than one day: hr. min.

9. Birthplace: Frederick Md.
(Town, county, and state)

10. Usual Occupation: Invalid

11. Industry or business:

FATHER
12. Name: Washington Smith
13. Birthplace: Frederick Md.

MOTHER
14. Maiden Name: Julia Ogle
15. Birthplace: Frederick Md.

16 (a) Informant: Maude Fink
(b) Address: 46 E. West St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/47 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet
Location: Frederick Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 617 St. Paul St.

19 (a) MAR 29 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 26th 1947, at 12 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 — 1946, to March 26 1947, and that I last saw h. alive on March 26 1947.

Immediate cause of death: Marked Cerebral Hemorrhage — Duration:
Due to: Adv. atherosclerosis
Due to:
Other Conditions: Chr. Nephritis
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Louis Jacob M. D.
Address: 1700 Eutaw Pl. Date signed: 3-28-47

X

J.H. FRENKIL 1422 EAST AVE

G50133

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

Registered G50133

Please write plainly, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 138 W. Mosher Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 138 W. Mosher Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES HOLLIE

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8, 1941

8. AGE: Years 6 | Months 0 | Days 19 | If less than one day hr. min.

9. Birthplace Person County, N. Car.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John H. Hollie
13. Birthplace Danville, Va.

MOTHER
14. Maiden Name Mabel M. Reece
15. Birthplace Danville, Va.

16 (a) Informant John H. Hollie
(b) Address 138 W. Mosher Street

17 (a) Removal (b) Date thereof Mar. 29, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Burchwood Annex
Location Roxboro, N. Car.

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) MAR 29 1947 (b) Hunting for William Cook
(Date received by registrar) (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 27 1947, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/27 1947 to 3/27 1947 and that I last saw him alive on 3/27 1947.

Immediate cause of death	Duration
Pneumonia Lobar	
Due to Rheumatic Heart	
Due to Carbon Dioxide Poisoning	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John H. Frenkil M. D.
Address 1422 East Ave Date signed 3/27/47

Howard L. Venable, M. D.

VS 150

G50134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

Registered No. G50134

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3246 Kingsley St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3246 Kingsley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James L Baxter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Anna B (Schlining)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 2 1868

8. AGE: Years	Months	Days	If less than one day
78	6	26	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Baxter
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs Anna B Baxter
(b) Address 3246 Kingsley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 31 '47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3901 Frederick Rd

18 (a) Funeral director Harry H Wetzel
(b) Address 4101 Edmondson Ave

19 MAR 29 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1935 to 3/28 1947 and that I last saw him alive on 3/27 1947.

Immediate cause of death	Duration
(a) Pulmonary Tuberculosis	8 Months
Due to	
Due to	
Other Conditions Chronic Bronchiectasis (Include pregnancy within 3 months of death)	15 Years

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Elliot W Johnson M. D.
Address 3432 Druid Park Dr Date signed

VS 150

G50135

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13c

Registered No. G50135

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 609 N Carrollton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 609 N. Carrollton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel Mc Fadden

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	C	married

6 (b) Name of husband or wife Annie Green
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 7, 1900

8. AGE: Years	Months	Days	If less than one day
46	7	19	hr. min.

9. Birthplace Florence, S.C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name David Mc Fadden
13. Birthplace Florence, S.C.

MOTHER
14. Maiden Name Mary Mc Addo
15. Birthplace Florence S.C.

16 (a) Informant Annie Mc Fadden
(b) Address 609 N Carrollton Ave,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-30-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St

19 MAR 29 1947 (Date rec'd by registrar) (b) Kathryn Fox Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 26, 1947, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 20 1947 to Mar 26 1947 and that I last saw him alive on Mar 20 1947.

Immediate cause of death	Duration
(a) Acute Tuberculosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos. J. Woolums M. D.
Address Elkridge, Md Date signed 3-28-47

VS 150

G50136

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered G50136

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline St
(c) Hospital or institution: St. Joseph's Hospital or
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2909 Reese St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Fred S Stanley

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Colored	

6 (b) Name of husband or wife Annie R. Stanley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 13, 1887

8. AGE: Years	Months	Days	If less than one day
59	3	15	hr. min.

9. Birthplace Beechhaven, N. C. (Town, county, and state)
10. Usual Occupation Night Watchman.
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Mrs. Annie R. Stanley
(b) Address 2909 Reese St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 31, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katye A. Williams
(b) Address 322 N. Schroeder St

19 (a) MAR 30 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/28 1947 at 2:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/9/47 to 3/28 1947.
and that I last saw h.[illegible] alive on 3/27 1947.

Immediate cause of death: Cardiorespiratory failure — Duration
Due to: Cerebral Hemorrhage
Due to: Hypertension
Other Conditions
(Includes pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Arthur J. Ouer
Address St Josephs H Date signed 3/28/47 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered 50137

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount Ave.
(c) Hospital or institution: Church Home & Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 29
(If outside city or town limits, write RURAL and give town)
(d) Street No. 508 Rock Glen Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Edward Guntrum.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male.	White	Married.

6 (b) Name of husband or wife Hazel G. Guntrum.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 9, 1886.

8. AGE: Years	Months	Days	If less than one day
60	6	19	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Bailoff
11. Industry or business Police Court

FATHER
12. Name George Wm. Guntrum
13. Birthplace Germany

MOTHER
14. Maiden Name Cristina Drechsler
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Hazel G. Guntrum
(b) Address 508 Rock Glen Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/31/47 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 29 1947 (Date received by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28, 1947, at 1.25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 20 1947, to Mar. 28, 1947, and that I last saw him alive on Mar. 28, 1947.

Immediate cause of death	Duration
Cardiac failure	
Due to Bronchopneumonia	
Due to	
Other Conditions Chronic Myocarditis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wayne N. Jacobus, MD. M. D.
Address Church Home & Hosp. Date signed Mar 28, 1947

VS 150

G50138

JL - 109312

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 112

G50138

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 29 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Rosemont
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2914 Louisiana Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ETHEL CLARA CANNON

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Rupert V. Cannon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28, 1891

8. AGE: Years	Months	Days	If less than one day
55	10	0	hr. min.

9. Birthplace Nebraska (Town, county, and state)
10. Usual Occupation School-Teacher - retired
11. Industry or business Baltimore City

FATHER
12. Name Charles F. Nagel
13. Birthplace Freeport, Ill.

MOTHER
14. Maiden Name Sarah Coigen
15. Birthplace Ill

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 3/31/47
(Burial, cremation, or removal) (month) (day) (year)
(c). Cemetery or crematory Meadowridge Memorial
Location Howard Co., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 29 1947 (b) Huntington for Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1947, at 8:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 20 1947, to March 28 1947, and that I last saw her alive on March 28 1947.

Immediate cause of death	Duration
Respiratory Failure	—
Due to Senile Asthenia	yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy No autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edmund D. Beacham
Address Balto City Hosp Date signed 28 Mar 47 M.D.

VS 150

G50139

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G50139

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belvedere & Green Spring
(c) Hospital or institution: Levindale
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Levindale Home (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME YETCHEN ROMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Simon Roman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1858.

8. AGE: Years	Months	Days	If less than one day
88	8	19	hr. min.

9. Birthplace Germany. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Loeb Katzenstein.
13. Birthplace Germany.

MOTHER
14. Maiden Name Bessie Weinberg.
15. Birthplace Germany.

16 (a) Informant Mrs. Belle Davis.
(b) Address 2815 W. Garrison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/30/47. (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Balto. Md.

18 (a) Funeral director Harris Sonnenheim Son
(b) Address 1902 Eutaw Place.

19 (a) MAR 29 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-29 1947 at 2 30/60 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-16 1946 to 3-29 1947 and that I last saw h[illegible] alive on 3-29 1947.

Immediate cause of death	Duration
Chronic cardio-vascular disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry Wagel M. D.
Address Levindale Home Date signed 3-29-47

VS 150

G50140 Hess G50140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Lombard Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Florida (b) County unknown
(c) City or town Miami
(If outside city or town limits, write RURAL and give town)
(d) Street No. 524 W. 28th St.
(If rural give location)
(e) Citizen of foreign country? Natural (Yes or No)
If yes, name country

3 (a) FULL NAME Henry H. Hess

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, (married), widowed, or divorced.
M	W	

6 (b) Name of husband or wife Eva Hess
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
66			hr. min.

9. Birthplace Martinsburg, W. Va.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Arthur Hess
13. Birthplace W. Va.

MOTHER
14. Maiden Name Eliz. Staub
15. Birthplace W. Va.

16 (a) Informant wife
(b) Address

17 (a) Burial (b) Date thereof Mar 31-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Martinsburg W. Va.

18 (a) Funeral director Geo E. Beyer Jr.
(b) Address 512 Hollins St.

19 (a) MAR 29 1947 (b) Huntington Williams M.D. Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-29 1947 at 4:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-25 1947 to 3-29 1947 and that I last saw him alive on 3-29 1947

Immediate cause of death	Duration
Pulmonary Edema	
Due to Glioblastoma, Right Temporal Lobe	
Due to	
Other Conditions arteriosclerosis generalized, moderate	

(Include pregnancy within 3 months of death)

Date of operation 3-27-47

Major findings of operation: Glioblastoma with extension

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J Brockman M. D.

Address University Hosp. Date signed 3-29-47

VS 150

PRINT WITH PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C50141

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1131a

Register No. C50141

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5304 Springlake Way
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 75yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5304 Springlake Way (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Ann Hall

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 10. 1861.

8. AGE: Years	Months	Days	If less than one day
85	6	18	hr. min.

9. Birthplace Oakland, Md (Town, county, and state)
10. Usual Occupation None.
11. Industry or business

FATHER
12. Name Elbridge Henry Hall
13. Birthplace ? Baltimore

MOTHER
14. Maiden Name Amanda Bosley
15. Birthplace Lockeysville

16 (a) Informant Lucy Bosley Hall Hicks
(b) Address 335 Yale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/31/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director H. A. Means and Son
(b) Address 805 N. Calvert St.

19 (a) MAR 29 1947 (b) Hunting for Williams Md

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 Mar. 1947 at 7:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 25 Mar. 1947, to 28 Mar. 1947, and that I last saw her alive on 28 Mar. 1947

Immediate cause of death	Duration
Cardiac failure, acute.	3/28/47
Due to Chronic myocarditis	
Due to Arteriosclerotic cardio-vascular renal disease	
Other Conditions — None.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph E. Muse Jr. M. D.
Address 3311 St Paul St Date signed 3/28/47

X

G50142

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1111 B

Registered No. G50142

Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 826 W. Baltimore.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 826 W Baltimore
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary T. Lowrey.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married.

6 (b) Name of husband or wife J. Frank

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 28, 1870

8. AGE: Years 76 | Months 10 | Days 28 | If less than one day hs. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation House work

11. Industry or business None

FATHER 12. Name Michael J Leonard

13. Birthplace Ireland

MOTHER 14. Maiden Name Annie Giblin

15. Birthplace England

16 (a) Informant W. Frank Lowrey

(b) Address 826 W. Baltimore

17 (a) Burial Female. (Burial, cremation, or removal) (b) Date thereof 3/31/47 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location 4300 Old Frederick Road

18 (a) Funeral director John Lowrey & Son

(b) Address 407-09 Gallows St

19 MAR 29 1947 (b) (Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/27/1947, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 27 1947 to 19, and that I last saw her alive on March 24 1947.

Immediate cause of death	Duration
Cardiac Failure	
Due to Pulmonary edema	
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles Townsend M.D.

Address 910 W. Lombard Date signed 3/29/47

VS-150

G50143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓61

Registered No. G50143

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hosp. 31
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 902 E. Lombard St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa Pitts

3 (b) If veteran, name war	3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	B	S

6 (b) Name of husband or wife —
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 4/8/1893

8. AGE: Years	Months	Days	If less than one day
63	11	17	____ hr. ____ min.

9. Birthplace Ga.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name Joseph Tompson
13. Birthplace Ga.

MOTHER
14. Maiden Name —
15. Birthplace

16 (a) Informant Emma Lewis
(b) Address 61 N. Dakota Ave. Edit

17 (a) Burial (b) Date thereof 3/29/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bentley ave

19 (a) ____ (b) ____
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/25 1947, at 3 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/24 1947, to 3/25 1947, and that I last saw her alive on 3/25 1947

Immediate cause of death	Duration
Resp. failure	
Due to Diabetic coma	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? ____
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____
(Specify type of place)
(e) Means of injury ____
23. Signature Mary at Kiel M. D.
Address Mercy Hosp Date signed 3/25/47

VS 150

X

G50144

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1240

Registered No. G50144

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd St. & Guilford Ave.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs. mos., or days) 23
(e) Length of stay in Baltimore (yrs. mos., or days) 23

2. USUAL RESIDENCE OF DECEASED:
(a) State Conn. (b) County ?
(c) City or town Stamford
(If outside city or town limits, write RURAL and give town)
(d) Street No. 55 Cove View Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Stephen F. Hall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male (~~Female~~) | 5. Color or race White | 6 (a) Single, married, widowed or divorced. Married

6 (b) Name of husband or wife Lucille Hall

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1888

8. AGE: Years 58 | Months 4 | Days 10 | If less than one day ____ hr. ____ min.

9. Birthplace New York City
(Town, county, and state)

10. Usual Occupation Sales Manager Branch

11. Industry or business Nat'l Cash Register Co.

FATHER
12. Name Stephen Hall
13. Birthplace Canada

MOTHER
14. Maiden Name Julia Abearn
15. Birthplace New York

16 (a) Informant Hospital Records
(b) Address 33rd St. & Guilford Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/29/47 (month) (day) (year)

(c) Cemetery or ~~Crematory~~ Putnam Cem.
Location Greenwich, Conn.

18 (a) Funeral director Wm. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md.

19 MAR 29 1947 (Date rec'd by registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28, 1947, at 10:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 5, 1947, to March 28, 1947, and that I last saw h~~im~~ alive on March 28, 1947

	Duration
Immediate cause of death Acute Fellow atrophy	6 days
Due to Cancer's cirrhosis of the liver	?
Due to	
Other Conditions Hypertensive cardio-vascular disease.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. R. Freeman Jr. M. D.
Address Union Memorial Hosp. Date signed March 29, 1947

G50145 G50145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3018 Walbrook Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3018 Walbrook Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes Mary Graham

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Walter E. Graham

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28. 1870

8. AGE: Years 76 | Months 3 | Days 27 29 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Polk S. Shipley
13. Birthplace Md.

MOTHER
14. Maiden Name Isabelle Pease
15. Birthplace Md.

16 (a) Informant Walter E. Graham
(b) Address 3018 Walbrook Ave.

17 (a) Burial (b) Date thereof 3-31-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.

18 (a) Funeral director J. Howard Strong
(b) Address 3207 W. North Ave

19 (a) MAR 29 1947 Hunter for Williams, M.D. Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1947, at 8.10 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 11 1947 to Mar 27 1947 and that I last saw her alive on Mar 26 1947

Immediate cause of death	Duration
Angina Pectoris	1 wk.
Due to Arteriosclerosis —	5 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Isaac C. Dickson
Address 3055 N. North ave Date signed 3/28/47 M. D.

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C50146

510924

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C50146

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County.....
(c) City or town Morrisville (If outside city or town limits, write RURAL and give town)
(d) Street No. 904 Pennsylvania Ave (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Bernard S. Berlin

3 (b) If veteran, name war: None

3 (c) Social Security Account No.:

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elizebeth A.

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 7-26-83

8. AGE: Years 63 | Months 8 | Days 3 | If less than one day .....hr. .....min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Electrical Mfgr.

11. Industry or business President Heinemann Elec. Co

FATHER
12. Name William Berlin
13. Birthplace Germany

MOTHER
14. Maiden Name Anita Piza
15. Birthplace Germany

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/29/1947 (month) (day) (year)

(c) Cemetery or crematory .....
Location Trenton, N.J.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves.

19 MAR 29 1947 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 29 1947 at 9 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 2 1947 to Mar 29 1947 and that I last saw him alive on Mar 27 1947

Immediate cause of death	Duration
Aneurysm of left aorta with rupture into peritoneal	2 yrs
Due to Cardiac, with shock	
Due to Gen. Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature Maurice B. Dunstead M.D.

Address J H H Date signed Mar 29 1947

VS 150

G50147

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1950

G50147 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address LINDEN AVE. + MADISON ST.
(c) Hospital or institution:
MARYLAND GENERAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) 3 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3039 OAKLEY AVE. -15
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME FREDERICK CHARLES GELTCH

3 (b) If veteran, name war

3 (c) Social Security Account No. 184-03-6080

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife MARJORY
6 (c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) NOV. 4, 1907

8. AGE: Years	Months	Days	If less than one day
39	4	24 25	hr. min.

9. Birthplace PENNSYLVANIA
(Town, county, and state)
10. Usual Occupation FIELD REPRESENTATIVE
11. Industry or business Independent Pneumatic Tool Co

FATHER
12. Name Andrew Geltch
13. Birthplace Unknown

MOTHER
14. Maiden Name Mary Unknown
15. Birthplace Ireland

16 (a) Informant Marjory Geltch
(b) Address 3039 Oakley Ave -15

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Mar 29 1947 (month) (day) (year)
(c) Cemetery or crematory Harrisburg, Pa
Location Harrisburg, Penna.

18 (a) Funeral director Wm. Cook Inc
(b) Address 217 St. Paul St. Baltimore Md.

19 (a) (b) Registrar

MAR 30 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/29 1947, at 3:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/26 1947 to 3/29 1947 and that I last saw h IM alive on 3/28 1947

	Duration
Immediate cause of death CORONARY OCCLUSION AND ACUTE MYOCARDIAL FAILURE	2½ DAYS
Due to CORONARY ARTERY SCLEROSIS AND ADVANCED	
Due to RHEUMATIC HEART DISEASE	
Other Conditions PULMONARY EDEMA	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy ADVANCED RHEUMATIC HEART MYOCARDIAL INFARCTION

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles W. Stewart Jr. M. D.
Address MD. GEN. HOSP. Date signed 3/29/47

X

G50148

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G50148 Registered No. 134a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 da
(e) Length of stay in Baltimore (yrs., mos., or days) 78 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 108 S Boulden St 24
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Carrie P. Cunningham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	widow

6 (b) Name of husband or wife Joseph A. Cunningham

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 9, 1869

8. AGE: Years	Months	Days	If less than one day
78	2	18	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Seamstress
11. Industry or business Mercy Hosp.

FATHER
12. Name George McCauley
13. Birthplace Balto

MOTHER
14. Maiden Name Elizabeth Robinson
15. Birthplace Scotland

16 (a) Informant Hosp. record.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 17 49 (month) (day) (year)
(c) Cemetery or crematory Saint Mary's Harden
Location Roland ave.

18 (a) Funeral director S. Walter Kay
(b) Address 6192 N. Boulden St.

19 (a) (Date rec'd by registrar) Wm Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-27-47 19..., at 10 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-5 1947, to 3-27 1947, and that I last saw h. alive on 3-27 1947

Immediate cause of death
Kidney failure

Due to congestive failure

Due to renal calculus Uremia

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James J. Farlach M. D.
Address Mercy Hosp. Date signed 3-27-47

VS 150

X

G50149

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G50149 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2008 Brookfield Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa Goulene

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Jacob

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Shepard
13. Birthplace Russia

MOTHER
14. Maiden Name Mollie
15. Birthplace Russia

16 (a) Informant Mrs Goulene
(b) Address 2008 Brookfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-30-47 (month) (day) (year)

(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton

18 (a) Funeral director Jack Lewis
(b) Address 1409 E Balto St

Mar 30 1947 (a) (b) Registrar
(Date filed by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1947, at 1.35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 13 1947 to March 30 1947, and that I last saw h[illegible] alive on March 30 1947

Immediate cause of death	Duration
Myocardial insufficiency	
Due to Arteriosclerotic and hypertensive c.v. disease	
Due to (Myocardial infarction) Recent & recent onset	
Other Conditions Pulmonary edema Bronchopneumonia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Heinr Beissinger M.D.
Address Sinai Hospital Date signed 3/30/47 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G50150 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1701 Ellamont Ave
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3401 Alto Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DORA HERMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Late Israel D.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Harry Snyder
13. Birthplace Russia

MOTHER
14. Maiden Name Faga ?
15. Birthplace Russia

16 (a) Informant Mr. Abe Schunick
(b) Address 3401 Alto Rd.

17 (a) Burial (b) Date thereof Mar 30/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh Cemetery
Location Windsor Mill Rd.

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1126 24 W. North Ave.

19 (a) (b)
(Date received by Registrar) Registrar

MAR 30 1947
VS 15a

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1947, at 9P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-20 1947 to 3-27 1947 and that I last saw h[illegible] alive on 3-27 1947

Immediate cause of death: Diabetes Mellitus
Chr. Card. vas. disease
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H Edmund Kurn M. D.
Address 3400 Hilton Rd Date signed 3/27/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G50151 Registered No. 113

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3330 8 Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 7

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Prince Georges
(c) City or town Hillside, MD (If outside city or town limits, write RURAL and give town)
(d) Street No. 1322 - 59th St (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME James Washington Drane

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife ✓

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20 1872

8. AGE: Years	Months	Days	If less than one day
74	8	9	hr. min.

9. Birthplace Washington D.C. (Town, county, and state)

10. Usual Occupation Actor

11. Industry or business

FATHER
12. Name B D Drane
13. Birthplace Virginia

MOTHER
14. Maiden Name Sophronia Ashford
15. Birthplace Virginia

16 (a) Informant Pt.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 1 1947 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Hghts Ave

MAR 30 1947 (Date rec'd by registrar)

19 (a) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-29 1947, at 10 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-22 1947 to 3-29 1947, and that I last saw him alive on 3-21 1947.

Immediate cause of death	Duration
respiratory failure	
Due to cardiac failure	
Due to Chronic emphysema	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ernest J Klein M. D.

Address Union Memorial Hosp Date signed 3-29-47

Langston Williams, MD

G50152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G50152 Registered No.

Correct age in upper case. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1150 Argyle Ave
(c) Hospital or institution: 17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 71 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1150 Argyle Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Carrie Rayner Browne

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	C	married

6 (b) Name of husband or wife Henry G. Browne
6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) Aug. 31, 1870

8. AGE: Years	Months	Days	If less than one day
71	6	27	hr. min.

9. Birthplace Baltimore, Balto, Md. (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Henry Rayner
13. Birthplace Anne Arundel Co, Md

MOTHER
14. Maiden Name Emma Maddon
15. Birthplace Cor Keysville, Md.

16 (a) Informant H. G Browne
(b) Address 1150 Argyle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 31 37 (month) (day) (year)
(c) Cemetery or crematory Loudon Mem.
Location Washington, D. C.

18 (a) Funeral director J. Preston Lindsay
(b) Address 519 Monroe St.

19 (a) Thurlington Williams, M.D. (Date received by registrar) Registrar

MAR 30 1937

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1937, at 2:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1936, to March 1937, and that I last saw her alive on 3-27 1937.

Immediate cause of death	Duration
Arterio-sclerotic cardiac disease	5 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. W. McDaniel M. D.
Address 817 N. Caroline Date signed 3-29-37

X

BALTIMORE CITY HEALTH DEPARTMENT

G50153

CERTIFICATE OF DEATH 95c

G50153
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1036 N. Central Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1036 N. Central Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude Jackson

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Col.

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 29, 1889

8. AGE: Years 57 | Months 10 | Days 26 | If less than one day hr. min.

9. Birthplace Balto. Md.
(City, county, and state)

10. Usual Occupation H - Home

11. Industry or business

FATHER
12. Name David Jackson
13. Birthplace Va.

MOTHER
14. Maiden Name Batty Oakley
15. Birthplace Va.

16 (a) Informant Katherine Louis Gaultney
(b) Address 1036 N. Central Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 30, 1947 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Robert L. Young
(b) Address 1216 N. Caroline St.

19 (a) MAR 29 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1947, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 29 1946 to March 25 1947, and that I last saw h[illegible] alive on March 25 1947.

Immediate cause of death Acute Acute
Basilar Brain Condition

Duration Dec 29 1946

Due to

Due to

Other Conditions Cardiac Hypertrophy
Hypertension.
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: No

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ralph G. Young

Address 1216 N. Caroline St. Date signed 3/28/47

PHYSICIAN
Underline the cause to which death should be charged statistically.

VS 150

Funeral from Williams Home

AB-107666 G50154

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G50154 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mos.-12days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 615 S. East Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Mary Harris

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-26-1896

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 27-1910

8. AGE: Years	Months	Days	If less than one day
36	3	1	hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation Waitress
11. Industry or business Pic A. Chic

FATHER
12. Name Daniel Harris
13. Birthplace Va.

MOTHER
14. Maiden Name Frances Peregory
15. Birthplace Va.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/31/1947 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (a) Filed MAR 30 1947 (b) (Date filed by Registrar) Registrar

MEDICAL CERTIFICATION AM

20. DATE OF DEATH March 28 1947, at 9.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-16 1947, to 3-28 1947, and that I last saw h. alive on 3-28 1947.

	Duration
Immediate cause of death: Cerebral Hemorrhage	9 hrs.
Due to: Coronary Occlusion	12 hrs.
Due to: Coronary Sclerosis	1 yr.
Other Conditions: Contributing Pneumonia	1 wk.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. D.
Address Date signed

VS 150

X

G50155
JL - 109554

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93c

G50155
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 521 (illegible) Ave. Lansdowne
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Kolarik

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Matilda
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 3, 1905

8. AGE: Years	Months	Days	If less than one day
41	3	24	hr. min.

9. Birthplace Yugoslavia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Andrew
13. Birthplace Yugoslavia

MOTHER
14. Maiden Name Mary Kolacek
15. Birthplace Yugoslavia

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-31-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Frank Ivach & Son
(b) Address 900 N. Chester St.

19 (Date rec'd by registrar) Clayton Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1947, at 2:55A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 25 1947, to March 27 1947, and that I last saw him alive on March 27 1947

Immediate cause of death: Cardiac Failure — Duration 3 days

Due to Rheumatic C.V.D.

Due to

Other Conditions Anemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: No Post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edmund B. Bearham M. D.
Address Balto City Hosp Date signed 27 Mar 47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C50156 94a C50156

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2719 W Fairmount Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2719 W Fairmount Ave (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Thattie E Rogers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Daniel Rogers

6 (c) If alive, give age D. years

7. Birth date of deceased (mo., day, yr.) 6/09/1870

8. AGE: Years 76 Months 9 Days 10 If less than one day hr. min.

9. Birthplace Nelson County Va
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER 12. Name Robert A Bowling

13. Birthplace Virginia

MOTHER 14. Maiden Name Emaline P Walton

15. Birthplace Virginia

16 (a) Informant Grant W Rogers

(b) Address 2719 W Fairmount Ave

17 (a) Removal & Burial (Burial, cremation, or removal) (b) Date thereof Apr. 1 47 (month) (day) (year)

(c) Cemetery or crematory Family Burial Plot

Location Portsmouth Va

18 (a) Funeral director C. B. Clippert & Son

(b) Address 1500 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 30 1947 Tuttington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1947, at 6:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 29 1947 to March 29 1947, and that I last saw h. alive on March 29 1947.

Immediate cause of death	Duration
CARDIAC FAILURE	one day
Due to CORONARY THROMBOSIS	one day
Due to ARTHEROSCLEROSIS	Several years
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Huntington Williams M.D.

Address 2325 Frederick Ave Date signed: M. 3 D. 31 47

X

G50157 LC# 606922

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

4/13 B

Registration No. G50157

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Pikesville, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 115 Brightside Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Kemp, Carol Ann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 11, 1944

8. AGE: Years	Months	Days	If less than one day
2	7 6	19	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Kemp, Francis R.
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Roberts, Dorothy
15. Birthplace Cockeysville, Md.

16 (a) Informant Kemp, Francis R (father)
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 3 47 (month) (day) (year)
(c) Cemetery or crematory Prospect Rd.
Location Pikesville

18 (a) Funeral director Landon M. Graves
(b) Address Same

MAR 31 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1947 at 5:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 23 1947 to March 30 1947, and that I last saw h.c.Y alive on March 30 1947.

Immediate cause of death	Duration
Respiratory failure	6 hrs.
Due to Pulmonary Tuberculosis Miliary Type	1 mo.
Due to	
Other Conditions Meningitis Tuberculous (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert J. Sheridan M.D.
Address Sydenham Hosp. Date signed 3/31/47

V S 150

X

G50158

AB-109394

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 309

Registered No. G50158

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4days
(e) Length of stay in Baltimore (yrs., mos., or days) 20yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 345 Canal Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Lindsay

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 28-1900

8. AGE: Years	Months	Days	If less than one day
47	0	6	hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof Apr 2 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Halstead
18 (a) Funeral director
(b) Address 9 E Lexington St Baltimore
19 (a) Date rec'd by registrar (b) Registrar

VS 150

MEDICAL CERTIFICATION AM

20. DATE OF DEATH March 28 1947, at 10:35M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-24 1947 to 3-28 1947 and that I last saw him alive on 3-28 1947

Immediate cause of death
Uremia — Duration 1 wk.

Due to Hypertensive C.V.D. — yrs.

Due to

Other Conditions Rt. Hemiplegia Suppl. Tabes Dors.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edmund B Beacham
Address Balto City Hosp Date signed 28 Mar 47

937

G50159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

G50159 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fairmount Ave & Broadway
(c) Hospital or institution: Church Home + Hospt.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore (18)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4202 Loch Raven Blvd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Mrs. Margaret Teresa Rouchard

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: F.

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife (deceased): Louis Edward Rouchard

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan. 12, 1861

8. AGE: Years 86 | Months 2 | Days 17 | If less than one day — hr. — min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Scott
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Kelly
15. Birthplace Ireland

16 (a) Informant Deceased

(b) Address —

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 2nd 1947 (month) (day) (year)

(c) Cemetery ~~or crematory~~ OLD U.S. National

Location Balto. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 127 St. Paul St.

MAR 31 1947 (Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 29 1947, at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 7 1947 to Mar 29 1947 and that I last saw her alive on Mar 29 1947.

Immediate cause of death: Peritonitis Acute — Duration: 7

Due to Chronic Cholecystitis + Cholelithiasis with empyema Due to the Gall Bladder — Duration: ?

Other Conditions Cirrhosis of the Liver — Duration: ?

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature J. Allen Moulton M. D.

Address Church Home & Hospt. Date signed 3/29/47

VS 180

G50160 BC# & 74177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161c

G50160 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edmund & Freme
(c) Hospital or institution Univ. Hosp. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Univ. Hosp 1353 N. Stricker
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Brown

3 (b) If veteran, name war: —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	Col.	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 21, 1947

8. AGE: Years	Months	Days	If less than one day
			21 hr. 45 min.

9. Birthplace Univ. Hosp. Baltimore, 1, Md.
(Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name James Brown Jr.
13. Birthplace Augusta, Ga.

MOTHER
14. Maiden Name Eva Coggill Brown
15. Birthplace Baltimore, Md.

16 (a) Informant Eva Brown (above)
(b) Address Baltimore, Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School MAR 26 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 31 1947 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1947, at 9a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/21 1947 to 3/22 1947 and that I last saw him alive on 3/22 1947

Immediate cause of death	Duration
Respiratory failure	
Due to Hyaline fatalis (?)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. W. Lyon M. D.
Address University Hosp. Date signed 3/26/47

X

G50161

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 158

Registration No. G50161

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: Maryland Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto Co.
(c) City or town Ferndale (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Shirley Miles

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/1946

8. AGE: Years | Months 3 | Days - | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Abe Miles
13. Birthplace N. Carl.

MOTHER 14. Maiden Name Pearl Edmunds
15. Birthplace Md.

16 (a) Informant Pearl Miles
(b) Address Ferndale, Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School MAR 26 1947

18 (a) Funeral director City Undertaking Co

(b) Address Commissioner of Health

MAR 31 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-24 1947, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-23 1947 to 3-24 1947 and that I last saw her alive on 3-24 1947

Immediate cause of death Resp. failure — Duration

Due to Marasmus

Due to

Other Conditions Congenital Weakness
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature P. Nichols Jr. M. D.

Address Univ. Hosp. Date signed 3-24-47

VS 150

X

G50162 Reg# 867856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161C

Registered No. G50162

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mercy
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2731 Maisel St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/10/47

8. AGE: Years | Months 2 | Days 6 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robat Thompson
13. Birthplace Md.

MOTHER
14. Maiden Name Jean ?
15. Birthplace Md

16 (a) Informant Jean Thompson
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School MAR 26 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 31 1947 (Date rec'd by Registrar) (Signature of Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-16 1947 at 6.4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-10-47 19 to 3-16 1947 and that I last saw h alive on 3-16 19 47

Immediate cause of death Respiratory failure — Duration

Due to Ent Keratiterus

Due to Erythroblastosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature V. Nichols Jr. M. D.

Address Univ. Hosp. Date signed 3-21-47

C50163

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C50163

Bl # B 73657 / 160a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home and Hospital V6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Newborn

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3409 Hudson St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Brzozowski (o)

3 (b) If veteran, name war: Newborn

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife: Newborn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20 1947

8. AGE: Years	Months	Days	If less than one day
—	—	2	— hr. — min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation Newborn

11. Industry or business

FATHER
12. Name Edward Brzozowski
13. Birthplace Maryland

MOTHER
14. Maiden Name Genevieve Zelazniecki
15. Birthplace Maryland

16 (a) Informant Father
(b) Address 3409 Hudson St. Balt, Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School MAR 26 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 31 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1947 at 12:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 20 1947 to March 22 1947 and that I last saw him alive on March 21 1947

Immediate cause of death	Duration
Intracranial Hemorrhage	
Due to Birth Injury	
Due to Child one of Twins	
Other Conditions Hydramnios	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: No
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph Dedutonis M. D.
Address Church Home & Hosp. Date signed 3/26/47

VS 150

G50164

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

Registered No. G50164

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Where the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 604 N. Pulaski St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 604 N Pulaski St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Albert Mattoon

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Blanche A. Mattoon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29-1873

8. AGE: Years 73 | Months 7 | Days 28 29 | If less than one day hr. min.

9. Birthplace Frederick Md
(Town, county, and state)

10. Usual Occupation Retired Clerk

11. Industry or business R R Express

FATHER
12. Name Chas Mattoon
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown West
15. Birthplace Unknown

16 (a) Informant Mrs Anita Leonard
(b) Address 117 S. Catherine St

17 (a) Burial (b) Date thereof 3/31/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Geo L. Beyer Jr
(b) Address 1512 Hollins St

19 MAR 31 1947 (Huntington Williams, M.D.)
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 19 47 at 10 30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 10 19 47 to March 27 19 47 and that I last saw h[illegible] alive on March 10 19 47

Immediate cause of death: Arteriosclerotic Cerebro Vascular Accident — Duration

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Albert J. Shochat M.D.

Address 2302 Edmondson Ave Date signed 3/31/47

VS 150

X

650165

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

Registered No. 650165

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3818 Norfolk Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ethel Lerner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years 59 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Hyman
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Joseph Lerner
(b) Address 3818 Norfolk Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-31-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phila Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1429 E Balto St

19 MAR 31 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

V S 190

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30, 1947, at 3:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 17, 1947 to March 30, 1947 and that I last saw h[illegible] alive on March 30, 1947.

Immediate cause of death	Duration
Cardiac Failure	
Due to 1. Cerebral Arteriosclerotic heart disease	
Due to 2. Anemia	
Other Conditions Pernicious myocarditis Diabetes (Include pregnancy within 3 months of death)	

Date of operation March 19, 1947
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice L. Tetelbaum M.D.
Address Sinai Hospital Date signed 3-31-47

X

G50166

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G50166

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2113 Westwood Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2113 Westwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Chernoff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Nathan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years 78 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Morris

13. Birthplace Russia

MOTHER 14. Maiden Name unknown

15. Birthplace Russia

16 (a) Informant Melvyn H. Chernoff

(b) Address 3407 Wynchester Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-31-47 (month) (day) (year)

(c) Cemetery or crematory Mt. Carmel

Location Pikesville

18 (a) Funeral director Jack Lewis, Inc

(b) Address 1439 E. Balto. Huntington Williams, M.D.

19 (a) MAR 31 1947 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-29-1947, at 5:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/9 1947 to 3/29 1947, and that I last saw her alive on 3/28 1947.

Immediate cause of death	Duration
Hypertensive C-v. disease	1 yr
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward A. Kaelin M.D.

Address 1847 W. North Ave Date signed 3/31/47

VS 150

X

G50167

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G50167 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4101 LIBERTY HEIGHTS
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 60 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4101 LIBERTY HEIGHTS
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MINNIE ELLA SAMUELSON

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex FEMALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced WIDOW

6 (b) Name of husband or wife SAMUEL D. SAMUELSON

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 73 | Months | Days | If less than one day hr. min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name LOUIS L. MOSROW
13. Birthplace RUSSIA

MOTHER
14. Maiden Name ROSE
15. Birthplace RUSSIA

16 (a) Informant ROBERT M. SAMUELSON
(b) Address 4101 LIBERTY HEIGHTS

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3-31-47 (month) (day) (year)
(c) Cemetery or crematory BETH TFILOH
Location WINDSOR MILL RD.

18 (a) Funeral director Jacob Louis Inc.
(b) Address 1439 E. Baltimore ST.

19 (a) MAR 31 1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-30 1947, at 7 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1946 to 3-30 1947 and that I last saw her alive on 3/30, 1947.

Immediate cause of death: Arteriosclerotic Cardio-vascular Disease — Duration: P

Due to

Due to

Other Conditions Coronary Thrombosis — Duration: 2 Hours

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature G. A. Grossman

Address 1109 N. Calvert St. Date signed 3/36/47

VS 150

C50168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 91a

Registered No. C50168

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 8yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4649 Briarclift Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alonzo Oliver Shepherd

3 (b) If veteran, name war None

3 (c) Social Security Account No. 232-01-9151

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Anna May

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 21, 1897

8. AGE: Years 49 | Months 5 | Days 7 | If less than one day ____hr. ____min.

9. Birthplace Washington Co. Md.
(Town, county, and state)

10. Usual Occupation Welding Inspector

11. Industry or business Black Mfg. Co.

FATHER
12. Name Otho Thomas Shepherd
13. Birthplace Wash. Co. Md.

MOTHER
14. Maiden Name Jennie Frances Kretzer
15. Birthplace Wash. Co. Md.

16 (a) Informant Mrs. Anna May Shepherd
(b) Address 4649 Briarclift Rd.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 3/31/47 (month) (day) (year)
(c) Cemetery or crematory Elmwood Cemt.
Location Shepherdstown, W. Va.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves.

19 MAR 31 1947 (Date rec'd by registrar) Huntington for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 19 47 at 7:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 1946 to Mar 28 1947. and that I last saw him alive on Mar 28 1947.

Immediate cause of death Uremia Coma — **Duration** 3 days

Due to Bacterial Endocarditis 12 Mo. ?

Due to (Staphylococcus Albus)

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. P. Von Schuckmann M.D.

Address 818 Edmondson Date signed 3/30/47

G50169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √61

Registered No. G50169

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 147 N Curley St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 147 N Curley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Martini

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband ~~or wife~~ Carrie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 27 1891

8. AGE: Years	Months	Days	If less than one day
53	7	1	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Police

FATHER
12. Name Adolph Martini
13. Birthplace Baltimore

MOTHER
14. Maiden Name Julia Schiller
15. Birthplace Baltimore

16 (a) Informant Carrie Martini
(b) Address 147 N Curley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 1-47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Loch Raven

18 (a) Funeral director John C Moran
(b) Address 3500 E Baltimore St

19 (Date rec'd by registrar) MAR 31 1947 (Signature) Harrington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 26 47 to Mar 28 47
and that I last saw him alive on Mar 25 47

Immediate cause of death — Duration

Asphyxiation
Due to Pneumonia Lobar
Due to
Other Conditions Diabetes Mellitus
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robt Curley M. D.
Address 2436 E Baltimore Date signed Mar 29 47

V S 150

108

G50170

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G50170 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 152 N Exeter (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY JOHNSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 73 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace (Town, County, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location Johns Hopkins Medical School MAR 28 1947

18 (a) Funeral director Commissioner of Health

(b) Address

MAR 31 1947 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/17/47 19 , at 3:A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John R Watts M.D. Medical Examiner.

Date signed 3/17/47

VS 191

correct age is especially important. Physicians: please write the

G50171

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G50171 114

BCH # 73858 160a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Charles
(c) City or town Waysido
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JUPITER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 21, 1947

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Elnore Jupiter
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Loc: Johns Hopkins Medical School MAR 27 1947

18 (a) Funeral director Commissioner of Health
(b) Address

MAR 31 1947 (Date rec'd by Registrar) Harrington Williams, M.D. Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH March 22 19 47 at 10:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 21 19 47 to March 22 19 47, and that I last saw him alive on March 22 19 47.

Immediate cause of death	Duration
Pulmonary atelectasis, bilateral	
Due to ? cerebral hemorrhage	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Russell Jordan M. D.
Address Johns Hopkins Hospital Date signed 3-24-47

VS 150

G50172

B# B 72890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G50172
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address West Balto Gen Hosp.
(c) Hospital or institution Rayner Clinic 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 1 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2122 N Calvert St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby German

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: S
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 9-1947
8. AGE: Years — Months — Days — If less than one day 1 hr. min.
9. Birthplace Balto md -
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Nelson German
13. Birthplace Balto Md

MOTHER
14. Maiden Name Hazel Davis
15. Birthplace Va

16 (a) Informant
(b) Address 2122 N Calvert St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Lo Johns Hopkins Medical School MAR 27 1947

18 (a) Funeral director Commissioner of Health
(b) Address
19 MAR 31 1947 Hubert F. Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-9 1947 at 7 P. M.
21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h[illegible] alive on 3-9 1947

Immediate cause of death	Duration
Atelectasis	
Due to	
Due to Prematurity	
Other Conditions Premature rupture of Membranes - 5hr	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Atelectasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature E. L. Triptau M. D.
Address W. Balto Gen Hosp Date signed 3-26-47

VS 150

X

G50173

BALTIMORE CITY HEALTH DEPARTMENT

BC# B-74001 CERTIFICATE OF DEATH 161c

Registered No. G50173

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wayne Ave 16
(c) Hospital or institution: West Balto Dew Stop -
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1910 Gwynn Oak Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Stephen Hilton

3 (b) If veteran, name war: none

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. ✓

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20 1947

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Elmer Hilton
13. Birthplace Baltimore

MOTHER
14. Maiden Name Alice Watson
15. Birthplace Baltimore -

16 (a) Informant
(b) Address 1910 Gwynn Oak Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Johns Hopkins Medical School MAR 27 1947

18 (a) Funeral director Commissioner of Health
(b) Address

MAR 31 1947 Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-21- 1947, at 11 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-20 1947, to 3-21 1947, and that I last saw h[illegible] alive on 3-21 1947.

Immediate cause of death	Duration
Erythroblastosis Foetalis - Foetus	
Due to Congenital Debility	
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: [illegible]

of autopsy: Erythroblastosis ?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Wm Balt Gen Hosp Date signed 3-23-47

VS 150

G50174

Square #3

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183

Registered No. G50174

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street
(c) Hospital or institution:
City Morgue
(d) Length of stay in hospital or inst. (yrs., mos., or days) [illegible]
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State D. C. (b) County
(c) City or town Washington
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5th Street, N.W.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank E. Shrader (?)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Undertaker
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY MAR 24 1947

18 (a) Funeral director Commissioner of Health
(b) Address (Signature of Funeral Director) Wm. Williams, M.D. Registrar

19 (a) MAR 21 1947 (Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11, 1947, at 4:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑, and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Found 3-11-47 24/4 O. M.
(b) Where did injury occur? Found at foot of Covington St
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work?
(d) Means of injury Found drowned

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 3-12-47

VS 191

G 50175 grave #2 Home - Back to Lumber yard 501 Central ave

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 77c

Registered No. 50175

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5-
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Unknown Charles Albert Berendt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years 45 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant August Berendt - Father
(b) Address 424 S. Second St. Philadelphia Pa.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location PUBLIC CEMETERY MAR 24 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 31 1947 (Date rec'd by registrar) Hyattsville, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 1947 at P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Acute Alcoholism

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 3-7-47

VS 191

G50176 Grave #1 G50176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1648

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dale Redman ?

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
20?			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Unknown
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY MAR 24 1947

18 (a) Funeral director Commissioner of Health
(b) Address
MAR 31 1947 (Date Rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 24, 1947, at 6:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-24-47 at 6:10P. M.
(b) Where did injury occur? Hanover Street Bridge
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No (harbor)
(d) Means of injury Jumped off bridge into water

23. Signature Howard J. Madden M.D. Medical Examiner.
Date signed 2-24-47

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correct age is especially important. Physicians: please write the ... every item of information should be carefully supplied. The ... CAUSES OF DEATH, WITH ONE ... LINE ... causes of death clearly and legibly.

G50177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33B

G50177 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1324 Penn. Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 Yrs. 7

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1324 Pennsylvania Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mildred Horner

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col.	Married

6 (b) Name of husband or wife Harrison Horner
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Jan. 24 1912

8. AGE: Years	Months	Days	If less than one day
35	2	5	hr. min.

9. Birthplace Athens, Ohio
(Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Herbert Reynolds
13. Birthplace Western West Va.

MOTHER
14. Maiden Name Margaret Morgon
15. Birthplace Athens, Ohio

16 (a) Informant Harrison Horner
(b) Address 1324 Penn. Ave.

17. (a) burial (Burial, cremation, or removal) (b) Date thereof Apr. 2 1947 (month) (day) (year)
(c) Cemetery or crematory West Union
Location Athens, Ohio
18 (a) Funeral director Dowler and Ferguson
(b) Address College St. Athens, Ohio
19 (a) MAR 31 1947 (Date received by registrar) (b) Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1947, at 4:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-26 1947 to 3-29 1947, and that I last saw her alive on 3-29 1947

Immediate cause of death: Myocardial Failure — Duration:
Due to:
Due to:
Other Conditions La Grippe
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:
23. Signature H. Franklin Phillips
Address 1443 Penna Ave Date signed 3-31-47

G50178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G50178

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 14 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Severn Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. Quarterfield Road
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George H Benton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Widowed

6 (b) Name of husband or wife Agnes Bontner
(c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) May 26, 1873

8. AGE: Years	Months	Days	If less than one day
73	10	3	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation unemployed
11. Industry or business

FATHER
12. Name Henry Benton
13. Birthplace Maryland

MOTHER
14. Maiden Name Charlotte ?
15. Birthplace

16 (a) Informant Mr Geo. M. Benton
(b) Address Severn, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/1/37 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd.

18 (a) Funeral director John F. Denny, Inc.
(b) Address 715 Light St.

19 (a) MAR 31 1937 (Date received) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1937, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 17 1937, to March 29 1937, and that I last saw he alive on March 22 1937.

Immediate cause of death	Duration
Bronchopneumonia, bilateral	2 weeks
Due to Cardiac Decompensation	
Due to Arteriosclerotic Heart Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Dutton M. D.
Address 1213 Light St. Date signed March 29

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50179 Huber BALTIMORE CITY HEALTH DEPARTMENT 93D Reg. G50179
CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 416 Pontiac Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Huber

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Margaret Muss
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Feb 4, 1857

8. AGE: Years 90 | Months 1 | Days 23 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business None

FATHER
12. Name Jacob Frederick
13. Birthplace Germany

MOTHER
14. Maiden Name Christina Krail
15. Birthplace Germany

16 (a) Informant Mrs Margaret Mehling
(b) Address 416 Pontiac Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/31/47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd

18 (a) Funeral director John F Denny Sons
(b) Address 414 Light St.

19 (a) MAR 31 1947 Registered number [illegible] Interring for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/27/47 19 , at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1946 to Mar 27 1947 and that I last saw h alive on 3/26 1947

Immediate cause of death: Heart failure
Due to: Hypostatic Pneumonia
Due to: Arteriosclerosis
Other Conditions: Cerebral Accident
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Rubin M. D.
Address 203 Pulaski Date signed

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Reg. No. G50180

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1101 E. Fort Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1101 E. Fort Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Matilda Jones

3 (b) If veteran, name war None

3 (c) Social Security Account No. 217-22-4530

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Joseph Jones

6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) June 15 1895

8. AGE: Years 51 Months 9 Days 24 If less than one day ____ hr. ____ min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Restaurant

11. Industry or business

FATHER
12. Name Frank Kuischer
13. Birthplace New York

MOTHER
14. Maiden Name Amanda Pleasants
15. Birthplace Pennsylvania

16 (a) Informant Mr Joseph Jones
(b) Address 1101 E. Fort Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-1-47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd

18 (a) Funeral director John F Kenny Inc
(b) Address 711 Light St.

19 (a) MAR 31 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28th 1947, at 9 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-23 1947 to 3-28 1947, and that I last saw her alive on 3-28 1947

Immediate cause of death	Duration
Cerebral Hemorrhage	12 hrs.
Due to Arteriosclerosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. L. Tolbert M. D.

Address 207 Fairfax Ave Date signed 3-31-47

X

G50181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

G50181 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edwood & Boone Sts.
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos. or days) 1½ days
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5615 Benton Heights
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Margaret Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 26-1901

8. AGE: Years 45 | Months 6 | Days 3 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore (town, county, and state)

10. Usual Occupation Stenographer

11. Industry or business

FATHER 12. Name Francis X. Miller

13. Birthplace Baltimore

MOTHER 14. Maiden Name Anna E Braun

15. Birthplace Baltimore

16 (a) Informant John G Miller

(b) Address 5615 Benton Heights

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 3-1947 (month) (day) (year)

(c) Cemetery or crematory Parkwood Cem

Location Rural

18 (a) Funeral director Ulrich Funeral Home

(b) Address 208 E Oliver St

MAR 31 1947 (Date rec'd by Registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1947 at 1:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 5 1947 to March 29 1947, and that I last saw her alive on March 28 1947.

Immediate cause of death Resp. Fail — Duration

Due to Generalized Carcinomatosis

Due to Agalloy Carcinoma of Ovary

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: Mar. 29, 1947 (Dr.)

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Richard D. Coon M. D.

Address University Hosp Date signed

VS 150

X 3/29/47

G50182 Birth Certificate G-74458

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G50182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver Street
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36 hr
(e) Length of stay in Baltimore (yrs., mos., or days) 36 hr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 827 McAlver St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Lucas

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/26/47

8. AGE: Years	Months	Days	If less than one day
		1	36 hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation —
11. Industry or business

FATHER
12. Name Mr. William M. Lucas
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Margaret Archbold
15. Birthplace Baltimore, Md.

16 (a) Informant Mother
(b) Address 857 McAlver Court

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Mount Holy Redeemer
Location 4430 Belair Rd
18 (a) Funeral director Edgar W. Conklin
(b) Address 924 E. Layer St.
MAR 31 1947 (Date received by registrar) Livingston Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/27 1947 at 10:30 M
21. I certify that death occurred on the date above stated; that I attended deceased from 3/26 1947 to 3/27 1947 and that I last saw him alive on 3/27 1947.

Immediate cause of death —	Duration
Cardio-respiratory failure	
Due to Sclerema Neonatorum	
Due to Prematurity	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Harry J. Nathan Jr.
Address St. Joseph's Hosp Date signed 28 Mar 47

VS 150

X

G50183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G50183 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3516 Greenspring Avenue 15
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 24 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3516 Greenspring Avenue (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William C. Harden, Sr.

3 (b) If veteran, name war —
3 (c) Social Security Account No. 213-05-0473

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Grace Myrtle Harden
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9- 1885

8. AGE: Years 61 | Months 9 | Days 18 | If less than one day hr. min.

9. Birthplace Frederick Co. Maryland (Town, county, and state)

10. Usual Occupation Section Hand

11. Industry or business W. E. Hooper & Sons Co.

FATHER 12. Name Joseph Harden
13. Birthplace Maryland

MOTHER 14. Maiden Name Mary Smithson
15. Birthplace Maryland

16 (a) Informant Mrs. Sofie M. Starleper
(b) Address 3516 Greenspring Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 31-1937 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 2431 Falls Road.

MAR 31 1937 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27- 1937, at 12-10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 24 1937 to Mar 27 1937 and that I last saw him alive on Mar 27 1937.

Immediate cause of death: Congestive Heart Failure — Duration

Due to Hypertensive C-V Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edwin L. Harmon M. D.
Address 4037 Falls Rd Date signed 3/28/37

VS 150

X

G50184

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 94a

G50184 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3107 O'Donnell St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3107 O'Donnell St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wojciech (George) Szulczewski

3 (b) If veteran, name war
3 (c) Social Security Account No. 220-01-1186

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Jozefa

6 (c) If dead, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 17 1876

8. AGE: Years 71 | Months - | Days 12 | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Canning

11. Industry or business McGuth's

FATHER 12. Name Unknown

FATHER 13. Birthplace Poland

MOTHER 14. Maiden Name Mary Anna Swichowski

MOTHER 15. Birthplace Poland

16 (a) Informant Mrs. Jozefa

(b) Address 3107 O'Donnell St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/1/47 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary Cem.
Location German Hill Road

18 (a) Funeral director Stephen Fialkowski

(b) Address 1000 S. Kenwood Ave.

19 (a) (Date received) MAR 31 1947 (Registrar) Harrington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 29 1947, at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1942 to 3/29 1947.
and that I last saw h[illegible] alive on 3/26 1947.

Immediate cause of death Coronary thrombosis — Duration 2 yrs.

Due to arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank C. Nunamaker M. D.

Address 333 S Ecod Ave, Date signed 3/31/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G50185 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1822 S. Charles St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1822 S. Charles St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Curtis C. Wood - (Woods)

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-03-4579

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Don't Know

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 9, 1878

8. AGE: Years	Months	Days	If less than one day
68	5	20	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Oyster Shucker

11. Industry or business

FATHER 12. Name James Wood

13. Birthplace Md.

MOTHER 14. Maiden Name Don't Know

15. Birthplace Md.

16 (a) Informant Mrs. Emma M. Daniels

(b) Address 1822 S. Charles St. Balto. 30, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 1, 1947 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill Cem.

Location Arbutus, Md.

18 (a) Funeral director C. Howard Evans

(b) Address 1400 S. Charles St Balto. 30, Md.

19 (a) (Registrar) (b) MAR 31 1947 Registrar

V 3450

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29, 1947 at 12:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1946 to Mar. 1947 and that I last saw him alive on March 29, 1947

Immediate cause of death

Coronary Heart disease

Due to Hypertension

Due to

Other Conditions Obesity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
1 day
1 year

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Isaac Muller M. D.

Address 1211 S. Charles St Date signed

X 3/29/47

G50186

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G50186
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave. & Dukeland St
(c) Hospital or institution West Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2310 Anoka Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Rose Hartman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Solomon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years 58 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation

11. Industry or business Housewife

FATHER
12. Name Morris Gotfrit
13. Birthplace Poland

MOTHER
14. Maiden Name Pearl
15. Birthplace Poland

16 (a) Informant Solomon Hartman
(b) Address 2310 Anoka Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 1/47 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale
Location Hamilton Ave.

18 (a) Funeral director SOL LEVINSON & BROS.
(b) Address 1124-26 W. North Ave.

19 (a) (Date rec'd by registrar) (b)
MAR 31 1947 Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1947 at 12 30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 17 1947 to March 30 1947 and that I last saw h[illegible] alive on 30 March 1947.

Immediate cause of death	Duration
Coronary occlusion	45 min.
Due to Arteriosclerotic Heart Disease	6 months
Due to	
Other Conditions Hypertension	20 yrs?

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. J. Gleason M. D.

Address 2834 St. Paul St Date signed March 30 1947

X

G50187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G50187
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 24 S. Spring Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK GIBBS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife (Ella) D

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 63 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Bertha Hopkins
(b) Address 1916 Mosher St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. County Md.

18 (a) Funeral director Joseph B. Locke Jr.
(b) Address 304 N. Central Ave

19 (a) 1947 (Filed by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1947, at 6.41 P M

21. I certify that I took charge of the remains described above, held an insp. & inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Ryan M.D.
Medical Examiner.
Date signed 3-29-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C50188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C50188

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt
(If outside city or town limits, write RURAL and give town)
(d) Street No. 825 W Baltcoat (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Delores Monie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 1936

8. AGE: Years 10 | Months 7 | Days | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Theodore Monie
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Nelson
15. Birthplace Md.

16 (a) Informant Priscilla Bolton
(b) Address 1113 Woodyear St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-1-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn.
Location Md

18 (a) Funeral director George G. Nelson
(b) Address 1303 Forrestman St

19 (a) (Date rec'd by Registrar) (b) Registrar

MAR 31 1947 Washington Millinery, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1947 at 4 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/28 1947 to 3/28 1947 and that I last saw her alive on 3/28 1947.

Immediate cause of death Subarachnoid Hemorrhage — Duration

Due to — Duration

Due to — Duration

Other Conditions Pulmonary Edema — Duration
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. R. Jennings M. D.
Address Univ. Hosp. Date signed 3/28/47

X

Dr. Sawyer G50189

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G50189 Registered No.

Every item of information should be carefully supplied. The... write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4912 Ross Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4912 Ross Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Wesley Kelly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Mary Louisa
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4th, 1860

8. AGE: Years	Months	Days	If less than one day
87	2	24	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. B. Maye Perry
(b) Address 4912 Ross Road

17 (a) Burial (b) Date thereof 4/1/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mount Olivet
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

MAR 31 1947 (b) Huntington Williams, M.D.
(Date rec'd by) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 28th, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 18 1947, to March 28 1947, and that I last saw h[im] alive on March 28 1947.

Immediate cause of death	Duration
Bronchio-pneumonia	10 days.
Due to	
Due to	
Other Conditions Chronic nephritis, Ca. Genitourinary	5 yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George Sawyer M. D.
Address 4308 Harford Rd. Date signed 3/31/47

G50190 BALTIMORE CITY HEALTH DEPARTMENT G50190
CERTIFICATE OF DEATH 163H

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write [URA] and give town)
(d) Street No. 3120 Lauravenue Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME Edward J Fahey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife. Julia M. Fahey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 7-1906

8. AGE: Years 40 | Months 6 | Days 21 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore - Md.
(Town, county, and state)

10. Usual Occupation Cab Driver
11. Industry or business Diamond Co.

FATHER
12. Name William Fahey
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Vendoveen
15. Birthplace Md.

16 (a) Informant Mrs. Elizabeth A Cox
(b) Address Route 2 - Box 373-A -

17 (a) Burial (b) Date thereof 4-1-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J Ruck
(b) Address 5305 Harford Road

MAR 31 1947
(Date rec'd by registrar)

(Signature for Williams, M.D.)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1947, at 3 45 P M

21. I certify that I took charge of the remains described above, held an Autopsy Ed Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation due to illuminating Gas

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 28 March 1947 3 45 P.M.
(b) Where did injury occur? 3130 Laura Ave
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No
(d) Means of injury Gen gas burners on kitchen stove

23. Signature William L Williford M.D.
Medical Examiner
Date signed March 29, 1947

VS 181

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. USE WHITE PAPER, WITH UNFADING INK.

D.O.A. accident Room
Med. Examiner case.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 577

✓ G50191 Registered No.

~~G50191~~

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 66

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2324 Loombridge St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Michael Oppolt.

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.:

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: DIVORCED

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 2 1880

8. AGE: Years 66 | Months 11 | Days 27 | If less than one day hr. min.

9. Birthplace GERMANY (Town, county, and state)
10. Usual Occupation BARBER
11. Industry or business

FATHER 12. Name GEORGE OPPOLT
13. Birthplace BALTIMORE, MD.

MOTHER 14. Maiden Name MARY ?
15. Birthplace BALTIMORE MD

16 (a) Informant Record
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3 31 47 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL RD.

18 (a) Funeral director MARTIN WE DIPPEL SONS
(b) Address 7110 BELAIR RD.

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 31 1947 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1947, at 6:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 29 1947, to Mar 29 1947 and that I last saw he was alive on Mar 29 1947

Immediate cause of death	Duration
Brain injury, Cause not apparent; possible brain tumor	Past hours
Due to Unknown	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address Johns Hopkins Hosp. Date signed 3-29-47

Dr. J. R. Lowe by Thomas J. Watkins, M.D. [signature] M.D.

G50192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G50192

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2876 Harford Rd
(c) Hospital or institution: 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2876 Harford Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Katherine Bender

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Jacob H Bender
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 22 1860

8. AGE: Years 86 | Months 7 | Days 7 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name ? Reutz
13. Birthplace Germany

MOTHER
14. Maiden Name unknown
15. Birthplace Germany

16 (a) Informant Anna L Koerp
(b) Address 2876 Harford Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 2. 1947 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Frederick Ave

18 (a) Funeral director Mr. & Mrs. John W. Teufel & Son
(b) Address 5311 Edmondson Ave.

19 (a) (Date received) MAR 31 1947 (b) Registrar Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1947, at 8 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 24 1946, to March 29 1947, and that I last saw h[illegible] alive on March 26 1947

Immediate cause of death	Duration
Coronary Embolism	20 MIN
Due to Arterio Sclerosis	14 Yr
Due to Hypertension	14 Yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature I F A Stevens M. D.
Address 2878 Harford Ave Date signed 3 30 47

X

G50193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1313

G50193 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3644 Hanover St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles D. Fant FANT

3 (b) If veteran, name war —

3 (c) Social Security Account No. 214-05-3686

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Zula M. Fant
(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) May 12 - 1887

8. AGE: Years 59 | Months 10 | Days 17 | If less than one day: 8 hr. min.

9. Birthplace Sperryville Va.
(Town, county, and state)

10. Usual Occupation Guard

11. Industry or business General Refractories

FATHER
12. Name William D. Fant
13. Birthplace Va

MOTHER
14. Maiden Name Ada Leake
15. Birthplace Va

16 (a) Informant Zula M. Fant
(b) Address 3644 Hanover St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 2 - 1947 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location A. A. Co. Md.

18 (a) Funeral director Mr. & Mrs. John H. Tinsley & Son
(b) Address 5311 Edmondson Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 1 MAR 31 1947

Hunting for Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 30 1947 at 7 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to Mar 30 1947 and that I last saw h— alive on Mar 29 1946.

	Duration
Immediate cause of death: Coronary Occlusion	Sudd
Due to: Chronic Nephritis & myocardotis.	2 yrs
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos. H. Phillips M. D.
Address 1939 Edmondson Date signed 3-31-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

G50194 — Registered No. ~~G50194~~

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3413 Harford Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Haas - HENRY W. HAAS

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-10-3925

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Esther M. E. Haas
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) Sept 12, 1896

8. AGE: Years	Months	Days	If less than one day
50	6	17	hr. min.

9. Birthplace Staten Island, N. Y. (Town, county, and state)
10. Usual Occupation Truck Inspector
11. Industry or business Western Maryland Dairy

FATHER — 12. Name Andrew Haas
FATHER — 13. Birthplace Germany
MOTHER — 14. Maiden Name Hellen Opitz
MOTHER — 15. Birthplace Germany

16 (a) Informant Esther M. E. Haas
(b) Address 3413 Harford Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr-1-1947 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A. A. Co. Md

18 (a) Funeral director Mr. & Mrs. John W. Teufel & Son
(b) Address 5311 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-29 1947, at 2:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-28 1947 to 3-29 1947, and that I last saw him alive on 3-29 1947

Immediate cause of death	Duration
Cerebral Vascular Accident	
Due to Rheumatic Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan B. Hyman
Address Sinai Hospital Date signed 3-29-47

VS MAR 31 1947

Williams, M.D.

G50195

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

G50195 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1504 W Lanvale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Roland Watson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20 1938

8. AGE: Years 8 Months 9 Days 9 If less than one day hr. min.

9. Birthplace Baltimore MD (Town, county, and state)

10. Usual Occupation School child

11. Industry or business

FATHER 12. Name Edward F Watson

13. Birthplace Richmond Va

MOTHER 14. Maiden Name Mabel Mildred Tay

15. Birthplace BALTIMORE MARYLAND

16 (a) Informant Mrs Mattie Watson

(b) Address 1504 W Lanvale Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 1. 1947 (month) (day) (year)

(c) Cemetery or crematory Mount Auburn Cemetery

Location Baltimore Maryland

18 (a) Funeral director Joseph A Linthicum

(b) Address 66 West Baltimore Street

19 (a) (Date rec'd by registrar) (b) Huntington Williams, MD

MAR 31 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/29 1947, at 12:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/2 1947 to 3/29 1947, and that I last saw him alive on 3/25 1947.

Immediate cause of death	Duration
Acute Glomerulo-Nephritis	27 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. C. Velcamp M. D.

Address 1131 Harlem Ave. Date signed 3/31/47

X

G50196

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G50196 ✓

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & Johns Hk
(c) Hospital or institution Womans Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 920 Hollins St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3 (a) FULL NAME Margaret Jane Ryan

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Thomas Ryan

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 16 1860

8. AGE: Years 86 | Months 9/0 | Days 14 | If less than one day ..... hr. ..... min.

9. Birthplace Ohio (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business .....

FATHER
12. Name Jacob Sanders (Sanders)
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Mary Karnes
15. Birthplace Ohio

16 (a) Informant Patient
(b) Address 920 Hollins St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4/1/47 (month) (day) (year)
(c) Cemetery or crematory Maple Grove
Location Milford, Ill.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto, Md.

(a) APR 21 1947 (To be filled in by registrar) (b) Huntington Williams M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1947 at 9:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 3 1946 to March 30 1947 and that I last saw h[illegible] alive on March 30 47.

Immediate cause of death	Duration
Cardio-Respiratory Failure	.....
Due to Hypertensive Arteriosclerosis and atheromatosis of coronaries	.....
Due to Hypertensive Arteriosclerotic Heart Disease	.....
Other Conditions Carcinoma of Stomach	.....

(Include pregnancy within 3 months of death)

Date of operation March 25 1947
Major findings of operation: Autopsy
Radiotherapy - Carcinoma Stomach
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M.
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury .....

23. Signature Maurland Edward Day M. D.
Address 4-E-33rd St Balto Date signed 3-30-47

G50197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G50197 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3120 St. Paul St.
(c) Hospital or institution: St. Paul Court Apts.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3120 St. Paul St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELLA RUDDACH

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 18, 1864

8. AGE: Years	Months	Days	If less than one day
82	7	12	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Washington Ruddach
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Mary Cliffe
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Blanche T. Secrist
(b) Address 3205 N. Calvert St. 18

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/1/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

(a) 3-31-1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30, 1947, at 3:30A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1945 to March 30 1947 and that I last saw h[illegible] alive on March 29 1947

	Duration
Immediate cause of death: Cerebral Hemorrhage	
Due to arterio sclerosis	18 yrs
Due to age	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature F. L. Keyser M. D.
Address [illegible] signer

X

G50198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30D

G50198 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 853 S. Dallas St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 853 S. Dallas St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE W. WENTWORTH

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
no	218-03-6957	Male	White	Widower

6 (b) Name of husband or wife Rosa Wentworth (nee Zinkand) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 6, 1880

8. AGE: Years	Months	Days	If less than one day
66	4	24	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Superintendent
11. Industry or business Miller Chemical Co.

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Arinthia Underhill
15. Birthplace Maryland

16 (a) Informant Mr. W. Harry Wentworth, son
(b) Address 2227 Reisterstown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/2/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) 31 1947 (Filed by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1st 1946 to March 30 1947 and that I last saw h[illegible] alive on March 29 1947

Immediate cause of death Arteriosclerotic C-V Dis. — Duration 9-15-46
aortic Aneurysm — 3-1-47
Complications of Hypertension — 3-28-47
Due to cause
Unprovoked Suicide
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Eastchurch M. D.
Address 842 S. East Ave Date signed 3-31-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50199

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G50199 Registered No. 937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Hospital for the Women of Md 12

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) Unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 300 E 30th (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Emily Adele Garton

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife [illegible] Garton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 26 July 1861

8. AGE: Years	Months	Days	If less than one day
85	8	5	hr. min.

9. Birthplace Willmington, Kent Co., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business None

FATHER
12. Name James A. Pennington
13. Birthplace Eastern Shore, Md. (Kent Co)

MOTHER
14. Maiden Name Martha Payson
15. Birthplace Eastern Shore, Md (Kent Co)

16 (a) Informant ~~Patient~~ Deceased
(b) Address As above

17 (a) Burial (b) Date thereof 4/2/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) (b) Registrar Huntington Williams, M.D.

MAR 31 1947

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 31 Mar 1947, at 5:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 18 Mar 1947 to 31 Mar 1947, and that I last saw h[illegible] alive on 31 Mar 1947.

Immediate cause of death Cardio-respiratory failure — Duration:
Due to Arteriosclerotic heart disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Walter Buckner, M. D.
Address Women's Hospital Date signed 31 Mar 47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 10

Registered No. G50200

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 118 E. Cross St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Welsh, Catherine

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21, 1929

8. AGE: Years	Months	Days	If less than one day
17	10	9	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Cashier

11. Industry or business

FATHER
12. Name Welsh, Joseph
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Carry Margaret
15. Birthplace Baltimore, Maryland

16 (a) Informant Father, Welsh, Joseph
(b) Address Same

17 (a) Burial (b) Date thereof 4-2-1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cathedral
Location Baltimore Md.

18 (a) Funeral director Thomas J. Fleming
(b) Address 1136 Light St.

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 31 1947

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1947 at 5 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 19 1947 to March 30 1947, and that I last saw h.e.r alive on March 30 1947.

Immediate cause of death	Duration
Cardiac failure	1 hr.
Due to Myocarditis	5 days
Due to Diphtheria	13 days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert J. Sheldon
Address Sydenham Hosp. Date signed 3/30/47 M.D.

X

G50201

HEALTH DEPARTMENT—CITY OF BALTIMORE

G50201

CERTIFICATE OF DEATH 937

1. PLACE OF DEATH

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 5609 Benton Hgts. Ave. St., 26 Ward)

Length of residence in city or town where death occurred ...yrs. ...mos. ...ds. How long in U. S. If of foreign birth? ...yrs. ...mos. ...ds.

2. FULL NAME John Asa Williams

(a) Residence: No. 5609 Benton Hgts. Ave. St., 26 Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
M	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE of~~ Anna E. Williams

6. DATE OF BIRTH (month, day, year) 11 – 5 – 1887

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
59	4	24	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Rubber Worker

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. U.S. Rubber Co.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore

FATHER

13. NAME John Williams

14. BIRTHPLACE (city or town) (State or country) Baltimore

MOTHER

15. MAIDEN NAME Alice Bentz

16. BIRTHPLACE (city or town) (State or country) Baltimore

17. INFORMANT Alice Bentz – wife

(Address) 5609 Benton Hgts. Ave.

18. BURIAL, ~~CREMATION, OR REMOVAL~~

Place Holy Redeemer Date Apr. 2, 1947

19. UNDERTAKER Lilly & Zeiler, Inc.

(Address) 403 S. Wolfe St. Zone 31

20. FILED MAR 31 1947 Huntington Williams, Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) March 29, 1947

22. I HEREBY CERTIFY, That I attended deceased from ..., 1945 to March 29, 1947

I last saw him alive on March 20, 1947. Death is said to have occurred on the date stated above, at 9 A.M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Coronary Thrombosis	3-47
Other contributory causes of importance:	
Chronic myocarditis	1943?

Was an operation performed? No Date of –

For what disease or injury? –

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ...Date of injury ..., 19...

Where did injury occur? ...
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased?

No If so, specify –

(Signed) J. Dawson Moore M. D.

(Address) 3105 Belair Rd

OCCUPATION is very important. See instructions on back of certificate.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50202

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Reference No. G50202

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green & Redwood Sts
(c) Hospital or institution:
University Hosp. 26
(d) Length of stay in hospital or inst. (~~yrs., mos., or days~~) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 332 S. Bouldin St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Doulain

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married

6 (b) Name of husband or wife Maria

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 3 1878

8. AGE: Years	Months	Days	If less than one day
68	7	26	hr. min.

9. Birthplace Balto — (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business —

FATHER
12. Name George Doulein
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret ?
15. Birthplace Germany

16 (a) Informant Maria A. Doulain
(b) Address 332 S. Bouldin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-1-1947 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem
Location German Hill Rd.

18 (a) Funeral director Lilly & Zeiler, Inc.
(b) Address 403 S. Wolfe St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1947, at 3 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-25 1947 to 3-29 1947 and that I last saw him alive on 3-28 1947.

Immediate cause of death	Duration
Cerebro-vascular accident	
Due to arteriosclerosis	
Due to	
Other Conditions Myocardial infarct	

(Include pregnancy within 3 months of death)
Date of operation None.
Major findings of operation:
of autopsy: None.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gerald A. Marten M. D.
Address University Hosp. Date signed 3-29-47

vs MAR 31 1947 Huntington Williams, M.D.

83a

G50203

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 184

Registered No. G50203

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1205 Etting Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Knox

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-03-1192

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2, 1910

8. AGE: Years	Months	Days	If less than one day
36	11	8	hr. min.

9. Birthplace Anderson, S.C. (Town, county, and state)
10. Usual Occupation Floor manager
11. Industry or business Cafe

FATHER
12. Name Kingfield Knox
13. Birthplace Anderson S.C.

MOTHER
14. Maiden Name Bessie Gray
15. Birthplace Anderson, S.C.

16 (a) Informant Mrs. Bessie Knox
(b) Address 1205 Etting St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/31/47 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave

19 MAR 31 1947 (b) Huntington for Williams, M.D.
(Filed by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28, 1947 at 10:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of heart and lung

Due to

Other Conditions Incised wounds of left shoulder and left forearm
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/28/47 at 9:30 P.M.
(b) Where did injury occur? 1007 Pennsylvania Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? Cafe
(d) Means of injury Firearm

23. Signature Earl L. Rose M.D.
Medical Examiner
Date signed 3/28/47

VS 191

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 110 B

C50204 C50204

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens + Caton Ave.
(c) Hospital or institution: St. Agnes Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 213 Chancery Rd 18 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles T. Bagby, Jr.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W	M

6 (b) Name of husband or wife Mildred Flack
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2, 1894

8. AGE: Years	Months	Days	If less than one day
53	—	29	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation City Planning
11. Industry or business Commission

FATHER
12. Name Charles T. Bagby
13. Birthplace Va.

MOTHER
14. Maiden Name Anna English
15. Birthplace Va.

16 (a) Informant James H. Flack
(b) Address 1119 Belleview Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 2, 47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director John D. Mitchell Sons
(b) Address 1906 Eutaw Place

19 (a) (Date received by registrar) (b) Baltimore, Md.

MAR 31 1947

150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/31/1947 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/28/1947 to 3/31/1947 and that I last saw him alive on 3/30/1947

Immediate cause of death Cardiac failure - 1st Pneumonia

Duration

Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] MD
Address [illegible] Date signed 3/31/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50205

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G50205 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Pulaski Sts.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) 86 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard Co.
(c) City or town Ellicott city
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GENERAL CHARLES D. GAITHER

3 (b) If veteran, name war: Yes 1st U.S.W.
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Marie Towson Gaither
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Nov 27, 1860
8. AGE: Years 86 Months 4 Days 2 If less than one day hr. min.
9. Birthplace: Howard Co. Md. (Town, county, and state)
10. Usual Occupation: retired
11. Industry or business: Police Commissioner.
FATHER 12. Name: Geo. R. Gaither
13. Birthplace: Md.
MOTHER 14. Maiden Name: Rebecca Dorsey
15. Birthplace: Md.
16 (a) Informant: Marie T. Gaither
(b) Address: Ellicott City Md.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 1/47 (month) (day) (year)
(c) Cemetery or crematory: Green Mount
Location: Greenmount Ave.
18 (a) Funeral director: John O. Mitchell & Son
(b) Address: [illegible] Baltimore, Md.
MAR 31 1947 (b) (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29, 1947. at 2:25 M
21. I certify that death occurred on the date above stated; that I attended deceased from 3-4-1947. to 3-29-1947.
and that I last saw h alive on 19
Immediate cause of death: Cardiac failure — Duration:
Due to: Arteriosclerotic & rheumatic heart disease
Due to:
Other Conditions: Pulmonary embolism.
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:
23. Signature: R. L. Hunter M.D.
Address: Bon Secours Hosp. Date signed: 3-29-47

VS 150

G50206 BALTIMORE CITY HEALTH DEPARTMENT G50206
Registered No.

CERTIFICATE OF DEATH 94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1415 Battery Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1415 Battery Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George F. Brown

3 (b) If veteran, name war
3 (c) Social Security Account No. 363-18-3495

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Annie M. Fix
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/2/1871

8. AGE: Years	Months	Days	If less than one day
75	9	27	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Family
(b) Address 1415 Battery Ave.

17 (a) B (Burial, cremation, or removal) (b) Date thereof 4/1/1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Ave.

18 (a) Funeral director James L. McCurley
(b) Address 1410 E. Fort Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 31 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-29 1947 at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1 1946 to 3-29 1947 and that I last saw him alive on 3-28 1947.

Immediate cause of death	Duration
Coronary Thrombosis	1 Day
Due to Arteriosclerosis	2 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. W. Collod M. D.
Address 207 Fort Ave. Date signed 3-29-47

X

G50207

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G50207 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 462 Arabia Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 462 Arabia Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John P. Durkee Sr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Rose E. Durkee
6 (c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) September 11 1863

8. AGE: Years	Months	Days	If less than one day
83	6	16	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Henry B. Durkee
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Julia Warfield
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Rose E. Durkee
(b) Address 462 Arabia Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/1/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Road

18 (a) Funeral director Henry H. Blight Jr.
(b) Address 4914 Belair Road

MAR 31 1947 (Date rec'd by registrar) (b) Registrar

Huntington Williams MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 29 1947 at 6 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1946, to Mar. 29 1947.
and that I last saw him alive on Mar. 29 1947

	Duration
Immediate cause of death ACUTE CARDIAC FAILURE	1 HR.
Due to ARTERIOSCLEROTIC HEART Disease	10 YRS.
Due to	
Other Conditions BENIGN PROSTATIC Hypertrophy (Include pregnancy within 3 months of death)	1 YR.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert J. Hurell Jas b M.D.
Address 1801 Eutaw Pl. Date signed 3/31/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50208

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 13 B

G50208
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2418 Wilkens Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2418 Wilkens Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edna Erma Wain

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	Married

6 (b) Name of husband or wife Charles C. Wain
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19, 1908

8. AGE: Years	Months	Days	If less than one day
59 /		11	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Charles F. Morhiser
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name May Ida Shipley
15. Birthplace Baltimore, Md.

16 (a) Informant: Charles C. Wain
(b) Address 2418 Wilkens Ave.

17 (a) Burial (b) Date thereof 4/2/47.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Frederick A. Dole
Address 1847 West Lombard St.

19 (a) (b) Washington Williams, M.D.
(Date rec'd by reg.) (Signature of registrar)

MEDICAL CERTIFICATION A.

20. DATE OF DEATH March 30, 1947, at 12:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1947 to March 30 1947. and that I last saw h. alive on March 29 1947.

Immediate cause of death Pulmonary tuberculosis — Duration 4 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature J. Edward Bender M. D.
Address 773 Medical & Dental Bldg. Date signed 3-31-47

VS 150

G50209

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 195E

G50209
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2320 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John S. Hayes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Hattie Wall Hayes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1901

8. AGE: Years 45 | Months 10 | Days 16 | If less than one day hr. min.

9. Birthplace -
(Town, county, and state)

10. Usual Occupation Freight Agent

11. Industry or business Pennsylvania Railroad

FATHER
12. Name -
13. Birthplace

MOTHER
14. Maiden Name -
15. Birthplace

16 (a) Informant Frank Vogler & Sons, Inc. Funeral Home
(b) Address 120 S. Main St., Winston Salem, N. C.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/31/47 (month) (day) (year)
(c) Cemetery or crematory Woodland Cem.
Location Winston Salem, N. C.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) MAR 31 1947 (Date received by registrar) (b) Washington, D. C. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1947, at 10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar pneumonia

Due to

Other Conditions Fracture 11th Dorsal Vertebra & Severance of Cord

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/26/47 11 A.M. 3/2
(b) Where did injury occur? Presidents Street Station
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? yes
(d) Means of injury Truck body fell on him

23. Signature Earl L. Vogler M.D.
Medical Examiner
Date signed 3/30/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

X 364

G50210

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √131a

G50210 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 432 N. Linwood Ave.,
(c) Hospital or institution: 6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 432 N. Linwood Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaretta Schmitt

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: none

4. Sex: Female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Late Michael L. Schmitt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): September 3, 1863

8. AGE: Years 83 | Months 6 | Days 26 | If less than one day hr. min.

9. Birthplace: Rosedale, Md. (Town, county, and state)

10. Usual Occupation: housewife at home

11. Industry or business

FATHER
12. Name: John Schaefer
13. Birthplace: Germany

MOTHER
14. Maiden Name: unknown
15. Birthplace: "

16 (a) Informant: John Schmitt - son
(b) Address: 432 No. Linwood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/1/47 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Road

18 (a) Funeral director: Charles E. Schimunek.
(b) Address: 2601-03 E. Madison Street

19 (a) Huntington Williams, M.D. Registrar (by registrar)

MAR 31 1947 VS

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1947, at 10:A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1940 to March 28 1947, and that I last saw h-- alive on March 28 1947

Immediate cause of death	Duration
Acute Intestinal Obstruction	3 days
Due to General arteriosclerosis	20 years
Due to	
Other Conditions Chronic Cardiac pain	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank J. Ayd
Address 2005 E. Monument St Date signed 3/31/47 M. D.

X

G50211

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G50211 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert St.
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 12
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 302 E 27th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Leo McCarthy

3 (b) If veteran, name war: World War 2

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: ANGELA EGAN McCARTHY

6 (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) JUNE 6 - 1912

8. AGE: Years 34 | Months 9 | Days 24 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation ASST. MANAGER GODDARD

11. Industry or business MILL WORKS

FATHER
12. Name Leo J McCarthy
13. Birthplace Baltimore

MOTHER
14. Maiden Name Catherine Strebb
15. Birthplace Baltimore

16 (a) Informant MRS. ANGELA EGAN McCARTHY
(b) Address 302 E. 27TH ST.

17 (a) BURIAL (b) Date thereof 4/2/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Chas. J. Evans & Son Inc
(b) Address 112 N. Mt. Royal Ave

MAR 31 1947 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-24 1947 to 3-30 1947 and that I last saw him alive on 3-30 1947

Immediate cause of death	Duration
Subdural Hemorrhage	
Due to Possible Ruptured Aneurysm	
Due to	
Other Conditions Pneumonia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Laurence J Finch M.D.
Address Mercy Hosp Date signed 4-2-47

VS 150

G50212

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G50212 Registered No. 83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1724 E.Oliver Street
(c) Hospital or institution * * 81
(d) Length of stay in hospital or inst. (yrs., mos., or days) *
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County 5
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1724 E.Oliver St/ (If no street address, give location) No
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William P.Delaney

3 (b) If veteran, name war	3 (c) Social Security Account No.
No.	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Margaret G.Delaney
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Feb. 12-1884

8. AGE: Years	Months	Days	If less than one day
63	1	18	hr. min.

9. Birthplace Baltimore, Md.
10. Usual Occupation Police-Lieutenant
11. Industry or business

FATHER
12. Name Patrick V.Delaney
13. Birthplace Baltimore

MOTHER
14. Maiden Name Jennie Morewood
15. Birthplace Baltimore

16 (a) Informant Margaret G.Delaney
(b) Address 1724 E.Oliver St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/2/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick road

18 (a) Funeral director Chas. J. Evans Son Inc.
(b) Address 118 W. Mt. Royal Ave

19 (a) APR 31 1947 (Date received by registrar) (b) Signature of Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1947 at 8.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/23 1947 to 3/30 1947, and that I last saw HIM alive on 3/29 1947.

Immediate cause of death	Duration
Cerebral hemorrhage	30 min.
Due to Essential Hypertension	
Due to	
Other Conditions Chronic bronchitis. generalized arteriosclerosis.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. C. Dunnigan M. D.
Address 31 E North Ave Date signed 3/30/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50213 57686

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G50213 Registered No. 1578

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Del. (b) County
(c) City or town Newark (If outside city or town limits, write RURAL and give town)
(d) Street No. 148 Main St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Andrew S. Wolf Walp.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. ✓

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-29-45

8. AGE: Years 1 | Months 6,7 | Days 1 | If less than one day hr. min.

9. Birthplace Delaware (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Andrew Walp

13. Birthplace Delaware

MOTHER 14. Maiden Name Elda Harrington

15. Birthplace Delaware

16 (a) Informant Record

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 2-47 (month) (day) (year)

(c) Cemetery or crematory Cemetery M E

Location Newark, Del.

18 (a) Funeral director Harry H. Pippin and Son

(b) Address Elkton Md

19 (a) Date received by registrar MAR 31 1947 (b) Registrar's signature Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-30 1947, at 8:43 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-14 1947, to 3-30 1947 and that I last saw him alive on 3-30 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Embolism, pulmonary	
Due to Post. endocarditis & pulmonary stenosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. Childs M.D.

Address Johns Hopkins Hosp signed 3-31-47

X

A 50214 4166692

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 926

A 50214 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Fred.
(c) City or town Thurmont.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hazel Wastler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-4-18

8. AGE: Years	Months	Days	If less than one day
29	-	27	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation housework
11. Industry or business

FATHER
12. Name Rusell Wastler
13. Birthplace Md.

MOTHER
14. Maiden Name Lulu Krise
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 3/47 (month) (day) (year)
(c) Cemetery or crematory Creagers Farm Md
Location

18 (a) Funeral director M. L. Creager & Son
(b) Address Thurmont, Md.

19 (a) (Date received by registrar) APR 1 1947 Tuntington Williamsville, Md (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March - 31 1947 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-25- 1947 to 3-31- 1947 and that I last saw her alive on 3-31- 1947

Immediate cause of death	Duration
Rheumatic heart disease with mitral stenosis insufficiency, tricuspid stenosis	
Due to	
Due to	
Other Conditions Bronchopneumonia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert C. Anderson M. D.
Address Johns Hopkins Hosp Date signed 31 March 47

X

AB-12036 45045

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G.50215 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12yrs-9mos.-16days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6200 Reisterstown Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Armstrong

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife: William D
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13-1882

8. AGE: Years	Months	Days	If less than one day
64	9	15	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation H.W.
11. Industry or business

FATHER
12. Name Thomas Mules
13. Birthplace Md.

MOTHER
14. Maiden Name Emma Burns
15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/31/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (Signature of local registrar) (b) Registered by Nov. Williams, M.D. Registrar

MAR 31 1947

VS 190

MEDICAL CERTIFICATION PM

20. DATE OF DEATH March 28 19 47, at 1.20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-12 19 34, to 3-28 19 47, and that I last saw h er alive on 3-28 19 47.

	Duration
Immediate cause of death: Bronchopneumonia	unknown
Due to: unknown cause	
Due to:	
Other Conditions: (1) Carcinoma of ascending Colon (2) Hydronephrosis left (Include pregnancy within 3 months of death)	unknown
Date of operation	
Major findings of operation:	
of autopsy: see above	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edwin C. Evans M. D.
Address Balto City Hospitals Date signed 3-29-47

X

G50216 BALTIMORE CITY HEALTH DEPARTMENT G50616 No.

CERTIFICATE OF DEATH 1937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 122 S. Monroe Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 122 S. Monroe Street
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Hugh E. Pettie

3 (b) If veteran, name war: None
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Nettie L. Pettie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 23, 1881

8. AGE: Years	Months	Days	If less than one day: hr.	min.
65	7	6		

9. Birthplace Culpepper, Virginia (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Retired

FATHER 12. Name Andrew P. Pettie
13. Birthplace Virginia

MOTHER 14. Maiden Name Isabelle H. Hitt
15. Birthplace Virginia

16 (a) Informant Richard Pettie
(b) Address 212 W. Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-1-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Md.

18 (a) Funeral director George F. Offutt
(b) Address 2101 W. Fredrick Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29, 1947, at 3:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 25 1947, to March 29 1947, and that I last saw him alive on March 29 1947.

Immediate cause of death	Duration
Cardiac Failure	
Due to Chronic Myocarditis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Scagnetti M. D.
Address 1524 E. Lombard St. Date signed 3/31/47

VS 150

G50217 968 E 972

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓163H

Registered No. G50217

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or Institution: St. Joseph's 9-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Born Here

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 12 St. Paul Street (If rural give location)
(e) Citizen of foreign country? Yes Ward 6 (Yes or No)
If yes, name country

3 (a) FULL NAME Paul Jones

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-07-7453

4. Sex	5. Color or race	6 (a) ~~Single, married, widowed, or~~ divorced.
M	W	Divorced

6 (b) Name of ~~husband or~~ wife Thelma Jones

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10 1905

8. AGE: Years	Months	Days	If less than one day
41	11	20	hr. min.

9. Birthplace Pittsburgh Pa. (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Building

FATHER
12. Name Charles W. Jones
13. Birthplace Pa.

MOTHER
14. Maiden Name Bella May Stewart
15. Birthplace Pa.

16 (a) Informant Susannah J. Kollen
(b) Address 1909 Boone St.

17 (a) Burial (b) Date thereof 4/1/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Moreland Park
Location Parkville Md.

18 (a) Funeral director Williams Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (Date rec'd by local reg.) APR 1 - 1947 (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/30/47 19 , at 12:54 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carbon Monoxide Poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/30/47 at 9:30 A.M.
(b) Where did injury occur? 1909 Boone Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Burned on Gas Burner

23. Signature John R. Davis, Medical Examiner. M.D.
Date signed 3/31/47

G50218 023 BALTIMORE CITY HEALTH DEPARTMENT G50218
CERTIFICATE OF DEATH 20E Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital ~~or institution~~: Sinai Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 320 E. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Herbert Hendrix

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-10-4097

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Almyna S.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 11th 1882

8. AGE: Years	Months	Days	If less than one day
64	3	20	hr. min.

9. Birthplace New Freedom Pa. (Town, county, and state)
10. Usual Occupation Pattern Maker
11. Industry or business B+O R.R.

FATHER
12. Name John B. Hendrix
13. Birthplace Pa

MOTHER
14. Maiden Name Sally B. Taylor
15. Birthplace Pa.

16 (a) Informant Almyna S. Hendrix
(b) Address 320 E. Lanvale St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 4/3/47 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Meadow Ridge
Location Dorsey Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

APR 1 - 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/31/1947, at 4:02 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/25 1947 to 3/31 1947 and that I last saw h.i.m. alive on 3/21 1947.

Immediate cause of death. Rupture of	Duration
~~aneurism~~ of ~~the~~ aorta	
Due to Arteriosclerotic H.V.D.? Luetic CVD??	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leon Rosenbaum M.D.
Address Sinai Hospital Date signed M. D. 3/31/47

X

G50219 BCH # 58847 755.2 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 157M Registered No. G50219

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1306 Winston Rd (If rural give location)
(e) Citizen of foreign country? .....(Yes or No)
If yes, name country .....

3 (a) FULL NAME Terry McKean

3 (b) If veteran, name war	3 (c) Social Security Account No. NONE
N	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 10-11-46

8. AGE: Years	Months	Days	If less than one day
	5	19	..... hr. ..... min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation .....
11. Industry or business .....

FATHER
12. Name Thomas McKean
13. Birthplace Mass

MOTHER
14. Maiden Name Bessie Griffin
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/2/47 (month) (day) (year)
(c) Cemetery or crematory Balto. Md.
Location .....

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

APR 1 - 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1947, at 10 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 5 1947, to Mar 30 1947, and that I last saw him alive on Mar 30 1947.

Immediate cause of death	Duration
Hemorrhage into intestines	2 days
Due to Cirrhosis of Liver	
Due to Congenital Atresia of Bile Ducts	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Mar 20, 1947
Major findings of operation: Congenital Atresia Bile Ducts
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature D D Leggett M. D.
Address Johns Hopkins Hospital Date signed 3/20/47

X

G50220

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G50220
Registered No.

AP-108889 002 1318

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26days
(e) Length of stay in Baltimore (yrs., mos., or days) 23yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 850 W. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Smith, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Gladys

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 24- 1900

8. AGE: Years 46 | Months 7 | Days 6 | If less than one day hr. min.

9. Birthplace Kerby, N.C.
(Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER
12. Name Cameron Smith
13. Birthplace N.C.

MOTHER
14. Maiden Name Lillie Womack
15. Birthplace N.C.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4/2/47 (month) (day) (year)
(c) Cemetery or crematory Marryoak
Location N.C.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 APR 1 - 1947 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1947, at 6AM M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-4 1947 to 3-30- 1947 and that I last saw h im alive on 3-30- 1947

Immediate cause of death Pulmonary tuberculosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C Rowell Hoffman M. D.
Address Baltimore City Hospitals Date signed 3/31/47

VS 150

X

G50221 341 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 83a Registered No. G50221

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 N Old Frog Lane
(c) Hospital or institution: Cold Spring Nursing home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5132 Belair Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Grace B Lounge

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 4 [illegible]

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Joseph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4 1902

8. AGE: Years	Months	Days	If less than one day
44	9	25	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John A Tilson
13. Birthplace Sweden

MOTHER
14. Maiden Name Sophia Joyce
15. Birthplace Salt Md

16 (a) Informant Albert G Tilson
(b) Address 5132 Belair Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/1/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director Wilson & Son
(b) Address 1217 E Fayette

19 (a) APR 1 - 1947 (Date rec'd by registrar) (c) Huntington for Williams, Mgr

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1947, at 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1946 to Mar 29 1947 and that I last saw h[illegible] alive on Mar 29 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day
Due to Cerebral Hemorrhage	
3 in past 6 mos.	
Due to Superadded high blood pressure	
Other Conditions Artery sclerosis of brain arteries	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Park
Address 2202 Wurth Date signed 3-31-47

VS 150

X

G50222

BALTIMORE CITY HEALTH DEPARTMENT

491 CERTIFICATE OF DEATH 107

Registered No. G50222

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1012 Baldwin St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 721 Ramsey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Eva Nicol

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) ~~Single, married~~, widowed, or divorced. Widowed

6 (b) Name of husband ~~of wife~~ Henry Otto Nicol

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 19th 1861

8. AGE: Years 85 | Months 6 | Days 10 | If less than one day hr. min.

9. Birthplace Washington D.C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name (Unknown) Zimmer
13. Birthplace Germany

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs Lydia Ramely
(b) Address 1939 Ramsey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 1st 1947 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 217 St. Paul St.

19 APR 1 - 1947 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 29th 1947, at 10a M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 17th 1947 to Mar. 29 1947 and that I last saw h.e alive on March 29 1947.

Immediate cause of death — Duration

Bronchio Pneumonia — 11 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]

Address 517 Scott St Date signed 3/31/47 M. D.

VS 150

G50223 420.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G50223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2212E North AVE.
(c) Hospital or institution: Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2212 E. North Avenue (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Bates

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife John F.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7, 1866

8. AGE: Years	Months	Days	If less than one day
980	8	24	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Mamie E. Hellwig
(b) Address 2212 E. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 2-47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md.

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) Date received by Local Registrar APR 1 1947 (b) Registered by Washington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/31 1947 at 8A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1945 to 3/31 1947
and that I last saw h alive on 3/31 1947

Immediate cause of death Myocardial Infarct — Duration 4 Weeks
Due to
Due to
Other Conditions Arteriosclerosis?
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 33 W. [illegible] Date signed

G50224

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

594 / 131a

G50224 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto General
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore MD
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1142 W Fremont St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Wilson (Washington)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years: 70 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Ella –
15. Birthplace Essex Co. Va

16 (a) Informant Miss Ella A. Jackson
(b) Address 1142 W Fremont St

17 (a) Burial (b) Date thereof 4-1-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto City

18 (a) Funeral director David L. Brown Wm
(b) Address 1642 Montgomery St

19 (a) APR 1 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/26 1947 at 5:11 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic & Cardiac Renal disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Seabrooke M.D.
Medical Examiner.
Date signed 3/26/47

G50225 5426 2160

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √61

Registered No. G50225

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1
(e) Length of stay in Baltimore (yrs., mos., or days) 37

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2435 McElderry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA SHULMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Louis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1888

8. AGE: Years	Months	Days	If less than one day
58	10	16	hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Harry Hurwitz
13. Birthplace Russia

MOTHER
14. Maiden Name Hannah Bernstein
15. Birthplace Poland

16 (a) Informant Mr. Louis Shulman
(b) Address 2435 McElderry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 1/47 (month) (day) (year)
(c) Cemetery or crematory Anshe Sphard Cong
Location Mt. Carmel Road

18 (a) Funeral director SOL LEVINSON & BROS.
(b) Address 1124-26 W. North Ave.

19 (Date received by Registrar) APR 1 - 1947 Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/31 1947, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/25 1947, to 3/31 1947, and that I last saw h[illegible] alive on 3/31 1947.

Immediate cause of death	Duration
Myocardial Infarction	
Due to Coronary Occlusion	
Due to Arteriosclerosis & Hypertension	
Other Conditions Diabetes Duodenal ulcer	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: on chart

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M.D.
Address Sinai Hospital Date signed 3/31/47

94a

G50226

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

9343 95c

Registered No. G50226

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. REVISED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 O'Donnell St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4700 O'Donnell St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles W. Webb

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-05-4085

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Elizabeth A. McCrackin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 5, 1887

8. AGE: Years	Months	Days	If less than one day
60	1	23	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John H.
13. Birthplace Baltimore

MOTHER
14. Maiden Name Anna Geiser
15. Birthplace Germany

16 (a) Informant Mrs. Webb.
(b) Address 4700 O'Donnell St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/1/47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) APR 1 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/30/47, 19..., at 8:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/12 19 47 to 3/30 19 47 and that I last saw h/ alive on 3/30 19 47

Immediate cause of death: (a) Cardiac decomp. — Duration 3 hrs.
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mitchell F. Rendernick M. D.
Address 1016 S. Caroline Date signed 3/31/47

VS 150

G50227 341 83a

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G50227

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 120 S.Calhoun St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 120 S.Calhoun St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William J.H.B.Wells

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Caroline M.Harrison
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9,1896

8. AGE: Years	Months	Days	If less than one day
50	8	21	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name William G.
13. Birthplace Howard Co. Md.

MOTHER
14. Maiden Name Mary Mohr
15. Birthplace Baltimore

16 (a) Informant Wife
(b) Address 120 S.Calhoun St.

17 (a) Burial (b) Date thereof 4/2/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Wash. Blvd.

18 (a) Funeral director Clarence F.Hoffmann
(b) Address 1639 Broadway

19 (a) APR 1 - 1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1947, at 6 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 24, 1938, to March 30 1947, and that I last saw h im alive on March 30 1947.

	Duration
Immediate cause of death Cerebrial Hemorage	
	3 days
Due to Cerebrial Arteriosclerosis	
Due to	
Other Conditions Arterial hypertension	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George A. Kupp M. D.
Address 3030 Edmondson Ave., Date signed 3/31/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G50228

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

491 / 107

G50228 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 Hilton Road.
(c) Hospital or institution: Ashburton Nursing Home.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Ashburton Nursing Home. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME CLARA N. PACHOLDER.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife M.S.Pacholder.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 4, 1860.

8. AGE: Years	Months	Days	If less than one day
86	3	26	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Isaac D. Nordlinger,
13. Birthplace Germany.

MOTHER
14. Maiden Name Nannette Eising,
15. Birthplace Germany.

16 (a) Informant Mr. David Nordlinger,
(b) Address Atlantic City, N.J.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/1/47. (month) (day) (year)
(c) Cemetery or crematory Har Sinai
Location Baltimore, Md.

18 (a) Funeral director Harris Levine & Son
(b) Address 1902 Eutaw Place.

19 APR 1 - 1947 (b) Huntingdon Williams, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30th, 1947 at A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1941 to March 1947 and that I last saw h alive on March 1947.

Immediate cause of death Bronchopneumonia — Duration 5 days

Due to

Due to

Other Conditions Hypertension, Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Isaac D. Nordlinger Jr. M. D.
Address 1207 Eutaw Place. Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50229 Loveless

581.0

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No. G50229

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 202 S. W. Fayette St
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3826 Ferndale Ave. Balto Md.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Luther B. Loveless

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-03-2310

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	

6 (b) Name of husband or wife Mrs Ella N. Loveless

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jany 13/1904

8. AGE: Years	Months	Days	If less than one day
43	3	18	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Manor Engraver

11. Industry or business

FATHER
12. Name John T. Loveless Sr.
13. Birthplace Chesapeake City Md.

MOTHER
14. Maiden Name Anna Marie Beinroger
15. Birthplace Baltimore Md.

16 (a) Informant Ella May Loveless
(b) Address 3826 Ferndale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 3/1947 (month) (day) (year)

(c) Cemetery or crematory Bethel
Location Laurel Md.

18 (a) Funeral director Ellsworth Sprague
(b) Address 3911 Liberty Heights Ave

19 APR 1 - 1947 (Registered by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1947 at 6 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 30 1947, to March 31 1947 and that I last saw him alive on March 31 1947

Immediate cause of death	Duration
Respiratory failure	
Due to uremia	
Due to Possible acute glomerulonephritis	
Other Conditions Virus pneumonia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: gross. curious lesion

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. H. Mottel M. D.
Address Bon Secours Hosp Date signed 3-31-47

VS 180

109a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50230 183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. G50230

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Howard & Madison Sts.
(c) Hospital or institution:
Maryland General Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 4
(If outside city or town limits, write RURAL and give town)
(d) Street No. 838 N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Birdie Wilhelm

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 23, 1878

8. AGE: Years	Months	Days	If less than one day
68	5	8	hr. min.

9. Birthplace Hampstead, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Richard Wilhelm
13. Birthplace Carroll Co., Md.

MOTHER
14. Maiden Name Rachel Fellers
15. Birthplace Carroll Co., Md.

16 (a) Informant Mr. Harold Todd
(b) Address 838 N. Fulton Ave.

17 (a) Burial (b) Date thereof 4/3/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Hampstead, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) APR 1 - 1947 Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-31 1947, at 8:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-27 1947 to 3-31 1947, and that I last saw her alive on 3-31 1947.

	Duration
Immediate cause of death Cardiac Failure	
secondary to Intestinal	
Obstruction secondary to	
Due to Generalized Carcinomatosis	
which originated in uterus	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Carlton Burkhead M. D.
Address Maryland General Hosp. Date signed 3-31-47

VS 150

G50231 490 BALTIMORE CITY HEALTH DEPARTMENT ✓108 Registered No. G50231

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 23 N. Bernice Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 23 N. Bernice Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY M. CLARK

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	217-01-3488

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary Clark
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1891

8. AGE: Years	Months	Days	If less than one day
55	4	6	hr. min.

9. Birthplace Jessups, Md. (Town, county, and state)
10. Usual Occupation Mgr.
11. Industry or business Urban Laundry

FATHER
12. Name Thomas L. Clark
13. Birthplace

MOTHER
14. Maiden Name Evangeline Comegys
15. Birthplace

16 (a) Informant Mrs. Mary Clark
(b) Address 23 N. Bernice Ave. 29

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/1/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) APR 1 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH March 28, 1947, at 10:47 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 15 1946, to March 28 1947.
and that I last saw him alive on 3/28 1947

Immediate cause of death Coronary Thrombosis — Duration 6 Mos.
Due to Arteriosclerotic Cardio-Vascular Disease.
Due to
Other Conditions Lobar pneumonia.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Elmore Longbein M.D.
Address 400 N. Payson St. Date signed 3/31/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50232 491 BALTIMORE CITY HEALTH DEPARTMENT G50232

CERTIFICATE OF DEATH 107

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 522 Overdale Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 522 Overdale Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) N
If yes, name country

3 (a) FULL NAME IDA MEGEE ZASTROW

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife George W. Zastrow
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 28, 1861

8. AGE: Years	Months	Days	If less than one day
86	1	1	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Thomas Morgan
13. Birthplace Unknown

MOTHER
14. Maiden Name Sarah Ann ?
15. Birthplace Unknown

16 (a) Informant Mrs. Myrtle Megee Brauer
(b) Address McCabe Ave.

17 (a) Burial (b) Date thereof 4/2/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) APR 1 - 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29, 1947 at 5:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 15 1947, to Mar. 29 1947, and that I last saw h[illegible] alive on March 28 1947

Immediate cause of death Myocardial Failure — Duration 2 da.
Due to Broncho-pneumonia. — 6 da.
Due to Senility — 27 yr.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nelson K. Gallagher M.D.
M. D.
Address Catonsville 28, Md. Date signed 3/31/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50233 401.4

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

Registered No. G50233

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 828 N. Mount St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 828 N. Mount St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME REILLY JONES

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years 53 | Months | Days | If less than one day hr. min.

9. Birthplace Salisbury Md (Town, county and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mattie L. Jones (wife)
(b) Address 828 N Mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 2 1947 (month) (day) (year)
(c) Cemetery or crematory Church Cemetery
Location Salisbury Md

18 (a) Funeral director V. A. Brohawn
(b) Address 1463 N. Carey St

19 (a) APR 1 - 1947 (Date rec'd by registrar) Washington Metropolitan

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29, 1947 8:19 a. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Rheumatic heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D. Medical Examiner.
Date signed 3/29/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50234 420.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G50234

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2924 Edmondson Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2924 Edmondson Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EDWARD A. BRANNING

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary C. Connelly
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Oct. 15, 1880

8. AGE: Years 66 | Months 5 | Days 15 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation FUNERAL DIRECTOR

11. Industry or business

FATHER
12. Name Henry C. Branning
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary C. Roach
15. Birthplace Baltimore Md.

16 (a) Informant Mary E. Branning
(b) Address 2924 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/2/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Martin Fahey & Sons
(b) Address 1827 N. North Ave.

19 APR 1 - 1947 (b) Huntington Williams M. D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1947 at 8 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 28 1947 to March 30 1947; and that I last saw h[illegible] alive on March 29 1947.

Immediate cause of death: Coronary thrombosis — Duration 2 hours

Due to: Arteriosclerotic type heart disease with hypertension — Duration years

Due to: Auricular fibrillation and congestive failure — Duration years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Michel M. D.
Address 2901 Edmondson Ave. Date signed March 31 47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50235 420.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G50235
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1218 Argyle Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1218 Argyle Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Riley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife Chas. C. Riley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, 1879

8. AGE: Years	Months	Days	If less than one day
67	8	24 25	hr. min.

9. Birthplace Harford Co., Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles Williams
13. Birthplace Md.

MOTHER
14. Maiden Name Reed
15. Birthplace Md.

16 (a) Informant Mamie Williams
(b) Address 1218 Argyle Ave

17 (a) Burial (b) Date thereof 4-3-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (b)
(Date rec'd by registrar) Registrar

APR 1 - 1947 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH March 31, 1947, at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mch 30 1947, to Mch 31 1947, and that I last saw h[illegible] alive on Mch 6 1947.

Immediate cause of death Coronary Thrombosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
About
48 hours

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Garland Shirell, M.D.
Address 1534 Druid Hill Ave Date signed April 1 1947

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G50236 450 97

Registered No. G50236

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 109 N. Chapel St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 109- N. Chapel St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALICE BERRY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ?
13. Birthplace Va

MOTHER
14. Maiden Name Ann Johnson
15. Birthplace Va

16 (a) Informant Clara Moore
(b) Address 653 Vine St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/4/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location A. A. County, Md

18 (a) Funeral director Joseph B. Lobs, Jr
(b) Address 1304 N. Central Ave

19 (a) APR 1 - 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30, 1947, at 11.35 M

21. I certify that I took charge of the remains described above, held an insp.& inq. thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Generalized arteriosclerosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D. Medical Examiner
Date signed 3-31-47

VS 191

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50237 443.1 ~~453.2~~ BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 937 Registered No. G50237

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 236 Amity St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 236 Amity St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rev. John H. Johnson. Sr.

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Laura Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1, 1879

8. AGE: Years 67 | Months 10 | Days 28 | If less than one day hr. min.

9. Birthplace Anne Arundel Co. Md.
(Town, county, and state)

10. Usual Occupation Preacher.

11. Industry or business

FATHER 12. Name Andrew Johnson
13. Birthplace Md.

MOTHER 14. Maiden Name Margaret Pack
15. Birthplace Md.

16 (a) Informant Mrs. David Johnson.
(b) Address 236 N. Amity St.

17 (a) Burial (b) Date thereof April 1, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Ashley
Location Town neck, Md.

18 (a) Funeral director Mrs. Katie A. Williams
(b) Address 322 N. Schroeder St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 190 APR 1 - 1947 Huntington Avenue, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1947 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 19, 1947 to March 29 1947 and that I last saw him alive on March 29 1947

Immediate cause of death Cerebral Hemorrhage
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

	Duration
Cerebral Hemorrhage	2 days

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Watts M. D.
Address 513 Carlton Date signed March 29 1947

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50238 ~~1707~~ 3007 ~~358 987~~ 152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G50238

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 dys.
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Balto. V
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1316 Riggs ave.
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME William Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bettie Williams

6 (c) If alive, give age 22 years

7. Birth date of deceased (mo., day, yr.) 11-8-09

8. AGE: Years 37 | Months 4 | Days 22 | If less than one day ..... hr. ..... min.

9. Birthplace Virginia (town, county, and state)

10. Usual Occupation .....

11. Industry or business Tailoring

FATHER 12. Name Lafayette Williams

13. Birthplace ?

MOTHER 14. Maiden Name Bardie ?

15. Birthplace ?

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 4/3/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Virginia
Location Matthews Co. Va

18 (a) Funeral director Geo. L. Nelson

(b) Address 1303 Pennsylvania Ave

19 (a) APR 1 - 1947 (Date received by registrar) (b) [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-30 1947 3:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-21 1947 to 3-30 1947 and that I last saw h[illegible] alive on 3-30 1947.

Immediate cause of death	Duration
Cachexia + Secondary anemia	
Due to Carcinoma bowel	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Pete L. Seaford M. D.

Address Johns Hopkins Hospital Date signed 3-31-47

X

G50239

BALTIMORE CITY HEALTH DEPARTMENT

293 CERTIFICATE OF DEATH 737

G50239 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 26 N. Norris Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dorothy Watson

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Horace Watson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1926

8. AGE: Years 21 | Months 20 | Days | If less than one day ..... hr. ..... min.

9. Birthplace Clarkstown, North Carolina (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Millard Moore
13. Birthplace North Carolina

MOTHER
14. Maiden Name Sarah Kenny
15. Birthplace North Carolina

16 (a) Informant Shaw Funeral Home
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-4-47 (month) (day) (year)
(c) Cemetery or crematory Whiteville N.C.
Location N. C.

18 (a) Funeral director George G Nelson
(b) Address 1303 Pennsylvania Ave.

19 (a) APR 1 - 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION 30

20. DATE OF DEATH March 28, 1947, at 11 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Edema

Due to

Other Conditions Anemia

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D. Medical Examiner.
Date signed 3/29/47

X

G50240 933 F911 BHP 68881

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1947

G50240 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1509 Presstman St
(c) Hospital or institution: 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1509 Presstman St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joyce Battle

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/27/47

8. AGE: Years	Months	Days	If less than one day
	2	3	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Joe Battle
13. Birthplace N.C.

MOTHER
14. Maiden Name Mary Perry
15. Birthplace N.C.

16 (a) Informant Joe Battle
(b) Address 1509 Presstman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-1-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn.
Location Md

18 (a) Funeral director George G. Nelson
(b) Address 1313 Pennsylvania Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS APR 1 - 1947 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1947 at 7:00 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Less death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Suffocation by inhalation of milky vomitus.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/30/47 at 6 P.M. 15/1
(b) Where did injury occur? 1509 Presstman St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? N.D.
(d) Means of injury Aspiration of vomitus

23. Signature George H. Merrill M.D. (Medical Examiner.)
Date signed 3-30-47

X

G50241 4401

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G50241
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2023 Pearson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2023 Pearson St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Eugene Matthews

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: M
5. Color or race: Col
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 5-10-1878
8. AGE: Years 68 Months 10 Days 21 If less than one day hr. min.
9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name
13. Birthplace Unknown

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Lillie Hammond
(b) Address 2032 Pearson St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-2-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Md
18 (a) Funeral director Geo. Kelso
(b) Address 1303 Pennsylvania Ave
19 (a) APR 1 - 1947 (Date recd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31, 1947, at 1251 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-7-1946 to 3-31-1947 and that I last saw h— alive on 3-20-1947

Immediate cause of death: Cerebral Hemorrhage — Duration 1 Day
Due to: Hypertension — 4 Months
Due to:
Other Conditions: Hypertensive Heart Disease — 4 Months
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 2243 Pearson Date signed 4/1/47

VS 3

530

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50242 443.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G50242

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1614 Shadyside Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1614 Shadyside Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John T. Costello.
3 (b) If veteran, name war: No
3 (c) No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Katherine
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 12 1870
8. AGE: Years 76 | Months 9 | Days 18 | If less than one day hr. min.
9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business B.O. RR Co.

FATHER
12. Name John Costello.
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Jane McGovern
15. Birthplace Ireland

16 (a) Informant John J. Costello.
(b) Address 1614 Shadyside Ave.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 2 47 (month) (day) (year)
(c) Cemetery or crematory Mt. Cathedral
Location Frederick Rd.
18 (a) Funeral director Martin H. Duffy & Son
(b) Address 710 Belair Rd.
19 (a) (Date rec'd by registrar) (b) Registrar

APR 1 - 1947 Huntington Hollowell, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1947, at 9:30 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from April 2 1945 to March 30 1947 and that I last saw him alive on March 28 1947

Immediate cause of death	Duration
Cerebral Artery Disease	2 yrs
Due to Hypertensive Cardio	?
Due to Vascular disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature John J. Costello
Address 5017 York Rd. Date signed 3/31/47 M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50243 493

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓107

G50243 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 816 Vine St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Moulton, Vernon

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.:
4. Sex: M
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Moulton, Emma
6 (c) If alive, give age 40 years
7. Birth date of deceased (mo., day, yr.) June 1, 1887

8. AGE: Years	Months	Days	If less than one day
59 58	10	-	hr. min.

9. Birthplace Howard County, Baltimore, Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Moulton, Richard
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Moulton, Emma — Wife
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/4/47 (month) (day) (year)
(c) Cemetery or crematory National Cem. Location Baltimore Md.

18 (a) Funeral director Metropolitan Funeral Home
(b) Address 927 N. Monroe St.

19 (a) 1947 (b) [illegible] by registrar Huntington Williams, Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1947, at 12 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 27 1947, to April 1 1947, and that I last saw h[illegible] alive on April 1 1947.

Immediate cause of death	Duration
Respiratory failure	30 min
Due to Pneumonia	12 days
Due to	over
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert J. Sheridan M. D.
Address Sydenham Hosp. Date signed 4/1/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G50244 443.0

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G50244 Registered No. 131a

1. PLACE OF DEATH: 1574 Division St.
(a) Baltimore City, Maryland ~~1703 Dittmans St~~
(b) Street address ~~3 [illegible] 2~~
(c) Hospital or institution: Provident Hospital 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1703 Dittmans St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Kylar

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex 35 Fe | 5. Color or race N | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1912

8. AGE: Years 35 | Months | Days | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Laundress

11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant James Kyler
(b) Address 1703 Dittmans St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. Co. Md.

18 (a) Funeral director Metropolitan Funeral Home
(b) Address 927 N. Pennsylvania Ave.

19 (a) 1947 APR 1 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/29 1947 at 7 05 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/25 1947 to 3/29 1947 and that I last saw h.e.r alive on 3/25 1947.

Immediate cause of death	Duration
Uremia	
Due to Hypertensive Cardio-Vascular Renal Disease	4 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address [illegible] Date signed 4/1/47

VS 150

MARGIN RESERVED FOR BINDING.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50245 431 BALTIMORE CITY HEALTH DEPARTMENT G50245

AB-109497 Bk B 3f660 **CERTIFICATE OF DEATH** 58c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1609 E. Chase St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jo-Ann Washington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 14- 1945

8. AGE: Years	Months	Days	If less than one day
1	3	15	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Arthur Washington
13. Birthplace S.C.

MOTHER
14. Maiden Name Rosa Brown
15. Birthplace S.C.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 4-1-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

(Date received) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 19 47, at 12.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-28- 19 47 to 3-29 19 47, and that I last saw h ay alive on 3-29m 19 47.

Immediate cause of death: Cardiac failure — Duration 1 da

Due to: Coronary occlusion / Acute hypocarditis — 1 da

Due to: — over 2 yrs.

Other Conditions: Pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury William E. Hughes

23. Signature

Address Balto City Hosp Date signed 4-1-47 D.

VS 150

G50246 422.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G50246

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DO NOT FOLD FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Lucy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 215 S. Robinson Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Serpico

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Rose
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 16, 1895

8. AGE: Years	Months	Days	If less than one day
51	8	14	hr. min.

9. Birthplace: Schenectady N.Y. (Town, county, and state)
10. Usual Occupation: Tailor & Musician
11. Industry or business: self employ

FATHER
12. Name: Michael Serpico
13. Birthplace: Italy

MOTHER
14. Maiden Name: Rose
15. Birthplace: Italy

16 (a) Informant: Michael Serpico (son)
(b) Address: 215- S. Robinson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/47 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Rd.

18 (a) Funeral director: Frank Della Rocca
(b) Address: 52 N. Wesley Ave

19 APR 1 - 1947 (a) Rec'd by (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/30/47 19 at 10:05 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Lauro M.D. Medical Examiner.
Date signed 3/31/47

VS 151

G50247

420.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G50247

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. DO NOT FOLD FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1815 E. Federal St.
(c) Hospital or institution:

81

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1815 E.Federal St. (If rural give location)
(e) Citizen of foreign country? none (Yes or No)
If yes, name country

3 (a) FULL NAME Andrea Cimino

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of ~~husband~~ wife: late Giuseppina

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): 12/17/1881

8. AGE: Years	Months	Days	If less than one day
66	3	14	____ hr. ____ min.

9. Birthplace: Cefalu, Italy (Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business

FATHER
12. Name: Salvatore Cimino
13. Birthplace: Italy

MOTHER
14. Maiden Name: Agostina Di Stefano
15. Birthplace: Italy

16 (a) Informant: Adelina Mancuso (Daughter)
(b) Address: 1815 E.Federal St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 4th 1947 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Rd. Baltimore Md.

18 (a) Funeral director: Frank Della Rocca
(b) Address: 52e N.Morley St.

19 (a) APR 1 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1947, at 6 20 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William S. McGrath M.D. Medical Examiner.
Date signed March 31, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50248 15

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered G50248

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Howard & Madison Sts
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Ann Arundel
(c) City or town Hanover (If outside city or town limits, write RURAL and give town) Rd
(d) Street No. Fort Meade Rd. Nr. Dorsey (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Donald Scott Terry
3 (b) If veteran, name war
3 (c) Social Security Account No. 214-20-2559

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Florence Terry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 10, 1890

8. AGE: Years	Months	Days	If less than one day
57	0	20	hr. min.

9. Birthplace Lynchburg (Town, county, and state) Virginia
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Charles Terry
13. Birthplace Virginia

MOTHER
14. Maiden Name Tithea Terry
15. Birthplace Virginia

16 (a) Informant Mrs. Branham Balto 27 Md.
(b) Address 2701 Daisy Ave. Halethorpe

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 2, 45 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie, Md.

18 (a) Funeral director Thomas W. Singleton
(b) Address 200 Crain Hway S.W. Glen Burnie, Md.

19 (Registered by registrar) APR 1 - 1947 Registrar of Vital Statistics, Baltimore, Md.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1947 at 4:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 29 1947 to Mar. 30 1947 and that I last saw him alive on Mar. 30 1947.

Immediate cause of death	Duration
Peritonitis	
Due to Perforation of Stomach	
Due to Carcinoma of Stomach	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Peritonitis due to perforation of Stomach due to Ca. of Stomach

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: William L. Schuster M. D.
Address Md. Gen. Hosp. Date signed 3-30-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C50219 | 52

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registry No. C50219

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5Y
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 138 N. Potomac St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BESSIE CARROLL WEAVER (Mrs. Edward J. Weaver)

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Edward J. Weaver Sr.

6 (c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): Jan. 27. 1883

8. AGE: Years: 64 | Months: 2 | Days: 4 | If less than one day: hr. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Oliver C. Bushman
13. Birthplace: Baltimore Md.

MOTHER
14. Maiden Name: Fannie Simpson
15. Birthplace: Baltimore Md.

16 (a) Informant: Edward J. Weaver
(b) Address: 138 N. Potomac St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Apr. 2. 1947 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Baltimore Md.

18 (a) Funeral director: HENRY SANDER & SONS. INC.
(b) Address: Baltimore Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS Form 1-50 Huntington Press, Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-31 1947, at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-5 1947, to 3-31 1947, and that I last saw her alive on 3-31 1947.

Immediate cause of death	Duration
Squamous cell carcinoma of sigmoid colon, primary in cervix	
Due to: with skull and fetus	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: J. B. Stanley, M. D.
Address: [illegible] Date signed 3-31-47

X

MARGIN RESERVED FOR BINDING. WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50250 410 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 92B G50250

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 921 N Schuter (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Isaac Pryor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-6-1918

8. AGE: Years 28 | Months 8 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Handy man

11. Industry or business

FATHER 12. Name William Pryor

13. Birthplace

MOTHER 14. Maiden Name Emma ?

15. Birthplace

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/1/47 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director Elroy O Wilson

(b) Address 1000 Brentwood Ave

19 (a) 4043 (Date) registered (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-27-47 19 , at 9:16 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-27 19 47 to 3-27- 1947, and that I last saw h[illegible] alive on 3-27- 1947.

Immediate cause of death	Duration
NOT DETERMINED BY AUTOPSY	
Due to RHEUMATIC HEART DISEASE	
MITRAL STENOSIS AND INSUFFICIENCY	
Due to TRICUSPID INSUFFICIENCY	
INFARCTS OF LUNG AND BRAIN,	
Other Conditions OBT	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: ABOVE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J Stubbins

Address Johns Hopkins Hosp Date signed 3-28-47 M. D.

Thomas J. Stubbins, M.D.

G50251 ✓ G50251

018.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 213

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton and Wilkens Ave
(c) Hospital or institution:
St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 620 Stamford Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alfred W. Criswell

3 (b) If veteran, name war: None

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife: Florence C. Criswell
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Oct. 17, 1901

8. AGE: Years	Months	Days	If less than one day
45	5	14	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business American Oil Co.

FATHER
12. Name William A. Criswell
13. Birthplace Carroll Co., Md.

MOTHER
14. Maiden Name --
15. Birthplace --

16 (a) Informant Mrs. Florence C. Criswell
(b) Address 620 Stamford Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/4/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

APR 1 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/1, 1947 at 7:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/13 1947 to 4/1 1947 and that I last saw h[illegible] alive on 4/1 1947.

Immediate cause of death: Cardiac Failure — Duration:
Due to Tuberculous Pericarditis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry W. Hollis M. D.
Address St. Agnes Hospital Date signed

X 4-1-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB-109098 G50252 490

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G50252 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2206 Corbin Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Derwart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4- 1861

8. AGE: Years	Months	Days	If less than one day
86	3	27	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John Derwart
13. Birthplace ?

MOTHER
14. Maiden Name Margaret Moeller
15. Birthplace ?

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-2-47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto

18 (a) Funeral director L. J. Buck
(b) Address 530 E. Hoffman Street

19 (a) (Date received by registrar) (b) Registrar

APR 1 - 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 19 47, at 11.40

21. I certify that death occurred on the date above stated; that I attended deceased from 3-12- 19 47 to 3-31- 19 47, and that I last saw h im alive on 3-31- 19 47.

Immediate cause of death: Respiratory Failure — Duration

Due to: Pneumonia

Due to: Chronic Bronchitis & Bronchiectasis

Other Conditions: Senile Tuberculosis Doctor

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. R. Scarborough

Address Balto City Hosp. Date signed 4-3-47

X

G50253 188 BALTIMORE CITY HEALTH DEPARTMENT ✓ G50253
Registered No.

CERTIFICATE OF DEATH 517

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver St
(c) Hospital or institution St Joseph's Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs 45 min
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 623 Dolphin St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr Harry Henry
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan 21 1909

8. AGE: Years	Months	Days	If less than one day
38	2	10	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Porter
11. Industry or business

FATHER
12. Name Joe Henry
13. Birthplace Md

MOTHER
14. Maiden Name Melvina Henry
15. Birthplace Md

16 (a) Informant Frank Henry
(b) Address 623 Dolphin St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 3 47 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Park
Location Balto
18 (a) Funeral director Rayner Sanders
(b) Address 412 E Preston St
19 (a) (Date received by registrar) Huntington Hollins, M.D.

APR 1 - 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1947, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 30 1947 to March 31 1947 and that I last saw h[illegible] alive on March 31 1947.

Immediate cause of death	Duration
Cardiac respiratory failure	
Due to Uremia	
Due to Carcinoma of Penis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of [illegible]
Extravasation of urine
of autopsy: Urine in abdominal [illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard S. Mikulicz, M.D.
Address [illegible] Date signed 3/31/47

Howard S. Mikulicz, M.D.

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50254 422.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G50254 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1312 Linden Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County –
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1312 Linden Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Andrew J. McHenry

3 (b) If veteran, name war –

3 (c) Social Security Account No. –

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife ~~November 30,~~

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November-30-1870

8. AGE: Years	Months	Days	If less than one day
76	3	29	hr. min.

9. Birthplace England (Town, county, and state)

10. Usual Occupation

11. Industry or business Retired

FATHER
12. Name Michael J. McHenry
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen Wallace
15. Birthplace Ireland

16 (a) Informant Vincent J. McHenry
(b) Address 1312 Linden Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-2-1947 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md

18 (a) Funeral director Flynn-Fleming
(b) Address 1426 Light St.

1947 [illegible] Registrar
(Date rec'd by reg.)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1947, at 8:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 10 1947 to March 29 1947, and that I last saw him alive on March 28 1947

Immediate cause of death	Duration
Myocardial Insufficiency	
Due to —	
Due to —	
Other Conditions Arteriosclerosis & Myocarditis (Include pregnancy within 3 months of death)	

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John C. Schenuch, M. D.
Address 1363 S. Charles St. Date signed 3/31/1947

VS 150

G50255 061.1 9 ✓ G50255

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Sydenham Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 7 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town ~~Essex~~ Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1918 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? YES (Yes or No)
If yes, name country.....

3 (a) FULL NAME Howard, Audrey (Audrey Howard ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	WH	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16, 1946

8. AGE: Years	Months	Days	If less than one day
1	2 15	16	..... hr. ..... min.

9. Birthplace Essex, Maryland
(Town, county, and state)

10. Usual Occupation.....
11. Industry or business.....

FATHER 12. Name Howard, Benjamin
13. Birthplace N. Carolina

MOTHER 14. Maiden Name Hansford, Mary
15. Birthplace W. Virginia

16 (a) Informant Father, Howard, Benjamin
(b) Address 1918 W. Fayette St.

17 (a)..... (b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory.....
Location Johns Hopkins Medical School APR 1 1947

18 (a) Funeral director Commissioner of Health
(b) Address.....

19 (a) APR 1 1947 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1947, at 10 95 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 27 1947, to March 27 1947, and that I last saw her alive on March 27 1947.

Immediate cause of death	Duration
Respiratory failure	10 hrs
Due to Pneumonia	—
Due to Pertussis	1 week
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature Albert J. Sheldon M. D.
Address Johns Hopkins Hosp. Date signed 3/28/47

X

G50256

420.0

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G50256

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 509 N. Carrollst
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL WRIGHT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	W

6 (b) Name of husband or wife.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
66			hr. min.

9. Birthplace Eastern Shore Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Lena Weight
(b) Address 641 W. Lee St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 4 2 47
(month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location Balto.

18 (a) Funeral director Walter B. Briggs
(b) Address 1300 W. Hamburg St.

APR 2 - 1947
(Date rec'd by registrar)

Registrar Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/30/47 19..., at 1:50 p M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to the death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Devers M.D.
Medical Examiner.

Date signed 3/31/47

X

G50257

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

341 +83a ✓ G50257 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 Caroline St
(c) Hospital or institution: St Joseph's Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) ½ hour.
(e) Length of stay in Baltimore (yrs., mos., or days) 9 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Dundalk.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2907 Dunglow Road.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Veronica Mc Auley.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/10/1873

8. AGE: Years 73 | Months 8 | Days 21 | If less than one day hr. min.

9. Birthplace New York City
(Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name Edward Reilly
13. Birthplace Ireland

MOTHER
14. Maiden Name Elizabeth Gargan
15. Birthplace Ireland

16 (a) Informant Mrs. D. M. Dixon
(b) Address 2907 Dunglow Rd Dundalk

17 (a) Removal (b) Date thereof 4-1-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Johnson Cem
Location New York

18 (a) Funeral director Wm J Gartner & Son
(b) Address Wirth & Penn Ave

APR 2 - 1947 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1st 1947 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1st 1947. to April 1 1947. and that I last saw her alive on April 1 1947.

Immediate cause of death: Coryza - Respiratory failure.

Due to: Cerebral vascular accident.

Due to: Hypertension

Other Conditions: essential.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John B Wheelhouse

Address 1400 Thop Date signed 4-1-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50258

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

341 83a

G50258 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital 12-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2628 N. Calvert (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Wilde

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/16/1870

8. AGE: Years	Months	Days	If less than one day
76	11	15	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation House Keeper
11. Industry or business

FATHER
12. Name Augustin Wilde
13. Birthplace Balto.

MOTHER
14. Maiden Name Virginia Bilson
15. Birthplace Va.

16 (a) Informant Eugene Wilde
(b) Address 2628 N Calvert St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/4/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Tilhou & Jones
(b) Address 1217 E Cold St.

APR 2 - 1947 (Date rec'd by Reg.) (b) Huntingtown Williamsport Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/1 1947 at 12 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1 1947 to 4/1 1947 and that I last saw her alive on 4/1 1947

Immediate cause of death	Duration
Respiratory Failure	
Due to Cerebro-vascular accident	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David H. Sills Jr M. D.
Address Mercy Hospital (State signed) 4/1/47

G50259

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

443.1 937

Registered No. G50259

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd St.
(c) Hospital or institution: UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4351 PARK HEIGHTS AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JESSE McWHORTA BARLOW

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-03-5782

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M.

6 (b) Name of husband or wife MRS. JESSE BARLOW
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) FEB 1, 1881

8. AGE: Years	Months	Days	If less than one day
66 65	11	30	hr. min.

9. Birthplace TEXAS
(Town, county, and state)
10. Usual Occupation NIGHT MAN, ARLINGTON APTS
11. Industry or business

FATHER
12. Name JOSEPH BARLOW
13. Birthplace NOT KNOWN

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace NOT KNOWN

16 (a) Informant MRS JESSE BARLOW
(b) Address SAME

17 (a) Burial (b) Date thereof 4/3/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 E. Paul St.

19 (a) APR 2 - 1947 (b)
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 31 1947 at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from MAR. 31 1947 to MAR 31 1947 and that I last saw HIM alive on MAR. 31 1947

	Duration
Immediate cause of death: CEREBRO VASCULAR ACCIDENT	5 hrs.
Due to: HYPERTENSIVE CARDIOVASCULAR DISEASE	?
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard F. Mullen M.D.
Address Date signed 3/31/47

Howard F. Mullen, M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50260 T5 422.1 G50260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G50260

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1423 Richardson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1423 Richardson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Otto Bohle

3 (b) If veteran, name war: N

3 (c) Social Security Account No. none

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Donna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17 1859

8. AGE: Years 87 | Months 10 | Days 11 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Artist

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Nanny Tobey
(b) Address 1423 Richardson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-3-47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Frederick Md

18 (a) Funeral director Milton Roop Jr
(b) Address 1217 E Fort Ave

APR 2 - 1947 (Date rec'd by registrar) (b) Huntington-Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1947, at 4:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-25 1947 to 3-30 1947 and that I last saw him alive on 3-29 1947.

Immediate cause of death	Duration
Chronic Myocardial Degeneration	2 yr.
Due to Arteriosclerosis	5 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. Sollod M. D.
Address 207 Fort Ave. Date signed 3-31-47

VS 150

G50261

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

528.2 ... 111 B

G50261
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 905 Shields Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Asia Hockaday

3 (b) If veteran, name war: W. W #1
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: C
6 (a) Single, married, widowed, or divorced: ?

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) - - 1897

8. AGE: Years 50 49 ? | Months — | Days — | If less than one day ... hr. ... min.

9. Birthplace N. Carolina (Town, county and state)

10. Usual Occupation Cook

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Elizabeth Spencer
(b) Address 905 Shields Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-2-47 (month) (day) (year)
(c) Cemetery or crematory Baltimore National Cem
Location Baltimore Md

18 (a) Funeral director Wellford Jackson
(b) Address 916 Penna ave

APR 2 - 1947 (Date received by registrar) (Signature of registrar) Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1947, at 3:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 30 1947 to March 30 1947. and that I last saw h- alive on March 30 1947.

Immediate cause of death: Acute Pulmonary Edema — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Milton Read M. D.
Address University Hospital Date signed
Redwood & Greene Sts

G50262

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G50262
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hosp. 14-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1522 McCulloh St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Lewis (HICKS)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	N	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5 mo. 1904

8. AGE: Years	Months	Days	If less than one day
42	10 9	27	hr. min.

9. Birthplace Eastern Shore, Md.
(Town, county, and state)

10. Usual Occupation House Work

11. Industry or business

FATHER
12. Name Geo. Sanford
13. Birthplace Md

MOTHER
14. Maiden Name Addie Stewart
15. Birthplace Md

16 (a) Informant Mrs Lillyann Craig
(b) Address 1523 Argyle ave

17 (a) Burial (b) Date thereof 4 2 47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director Wellington A Jackson
(b) Address 916 Pennsylvania ave

APR 2 - 1947
(Date rec'd by Registrar)

(b) Huntingtn Williams M.D.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/29 1947, at 7 35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/26 1947 to 3/29 1947, and that I last saw h[illegible] alive on 3/29 1947.

Immediate cause of death: Cerebro-Vascular Accident — Duration

Due to: Hypertension (Contributed)

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 4/1/47

G50263

BALTIMORE CITY HEALTH DEPARTMENT

602

CERTIFICATE OF DEATH 134a

Registered No. G50263

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2209 Homewodd Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2209 Homewood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER V. DOUGHERTY

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife EMMA DOUGHERTY
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Chief Clerk
11. Industry or business Police Dept.

FATHER
12. Name John Dougherty
13. Birthplace Md.

MOTHER
14. Maiden Name Eliz. Mahaney
15. Birthplace Ireland

16 (a) Informant Mrs. Walter Dougherty
(b) Address 2209 Homewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/2/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location City

18 (a) Funeral director WIEDEFELD AND SON
(b) Address GREENMOUNT AVE & 22ND

APR 2 - 1947

(Registered by) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30th 1947; at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 19[illegible] to March 30 19[illegible]; and that I last saw him alive on March 30 1947.

Immediate cause of death	Duration
Myocardial Degeneration.	4 Hrs
Due to Myocarditis.	
Due to Arteriosclerosis.	
Other Conditions Prostatic Hypertrophy.	

(Include pregnancy within 3 months of death)
Date of operation Nov 1946
Major findings of operation: Hypertrophy
of autopsy: Pedunculated Left Kidney.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Norman Mills M.D.
Address 592 E 22nd St Date signed 4/1/47

G50264

416335-196

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

45D ✓ G50264

Registered No. 416335

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3200 Vickers Rd. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Sarah Selis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife.....

6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) 12-6-1885

8. AGE: Years	Months	Days	If less than one day
61	3	27	....hr. ....min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation.....

11. Industry or business House Wife

FATHER
12. Name Leonard Snyder
13. Birthplace Russia

MOTHER
14. Maiden Name Beverly Geise
15. Birthplace Russia

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 2 / 47 (month) (day) (year)
(c) Cemetery or crematory Bath Tfiloh Cemet.
Location Windsor Mill Rd.

18 (a) Funeral director A.J. Keenan & Bro.
(b) Address 1324-26 W. North Ave.

19 APR 2 - 1947 (Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April - 1 - 1947 at 12 05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-20- 1947, to 4-1- 1947, and that I last saw her alive on 4-1- 1947

	Duration
Immediate cause of death Peritonitis	
Due to Ruptured duodenal ulcer	
Due to (Acute pneumonia, Spasmodic contracture of Diabetes Mellitus, Hypertension Cardiovascular Disease)	24 hours
Other Conditions (Include pregnancy within 3 months of death)	

Date of operation.....
Major findings of operation:.....
of autopsy: ruptured peptic ulcer

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature Maurice B. Dunstead M. D.

Address J H H Date signed Apr. 47

X

G50265 968 E 9-72

BALTIMORE CITY HEALTH DEPARTMENT ✓ G50265

CERTIFICATE OF DEATH 163 H Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2508 Park Heights Terrace
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2508 Park Heights Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Rosenblatt

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Horace R.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1912

8. AGE: Years 35 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation House Work.

11. Industry or business

FATHER
12. Name Wilhelm
13. Birthplace Germany

MOTHER
14. Maiden Name Emma
15. Birthplace Germany

16 (a) Informant Husband
(b) Address

17 (a) Burial Permit (Burial, cremation, or removal) (b) Date thereof 4-2-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Belair Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Baltimore St

APR 2 - 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1947, at 9:15 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Asphyxiation due to
Illuminating Gas

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury March 31, 1947 8:30 P M.
(b) Where did injury occur? 2508 Park Heights Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury? Illuminating Gas Burners or Heating Stove

23. Signature William F. Kelbert M.D. Medical Examiner
Date signed April 4, 1947

VS 191

650266 170

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

650266 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 Caroline St
(c) Hospital or institution: St Joseph's Hospital - 9 -
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2609 Ceil Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Barbara Anna Wicke

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 20-1866

8. AGE: Years	Months	Days	If less than one day
80	5	12	hr. min.

9. Birthplace Baltimore, Md. Germany
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name — Grogana
13. Birthplace Germany

MOTHER
14. Maiden Name — Grogana
15. Birthplace Germany

16 (a) Informant Richard W. Wicke
(b) Address 826 E. Joppa Rd., Towson

17 (a) Burial (b) Date thereof 4/3/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Prospect Hill Cem
Location Towson, Md.

18 (a) Funeral director John Burns & Sons
(b) Address Towson, Md.

19 APR 2 - 1947 (b) Huntington Williams, M.D.
(Accepted by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1, 1947 at 9:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 30 1947 to April 1 1947, and that I last saw h[illegible] alive on April 1 1947.

Immediate cause of death — Duration
Cardio-Respiratory failure
Due to Cardiac decompensation
Due to Coronary arteriosclerosis heart disease
Other Conditions Partial Malignancy Left Breast
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard Jameson M. D.
Address 24 W. Fayette St Date signed 93D 7/1/47

VS 150

G50267. 184 BALTIMORE CITY HEALTH DEPARTMENT G5D267.
Registered No.

CERTIFICATE OF DEATH 49a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Broadway St
(c) Hospital or institution: St Josephs Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town ~~Baltimore~~ Baynesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4652 Oakleigh Rd.
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Beatrice Marie Bayne.

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married.

6 (b) Name of husband or wife Isaac W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/4/99

8. AGE: Years	Months	Days	If less than one day
47 48	7	28	— hr. — min.

9. Birthplace Lock Haven Pa.
(Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business at Home

FATHER
12. Name John Tyson
13. Birthplace Lock Haven, Pa.

MOTHER
14. Maiden Name Mary Hunter
15. Birthplace Lock Haven, Pa.

16 (a) Informant Mrs. J. L. Whitford
(b) Address 8650 Oakleigh Rd., Baynesville

17 (a) Burial (b) Date thereof 4/4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Parkside, Md.

18 (a) Funeral director John Burns' Sons
(b) Address Towson, Md.

19 (APR 2 - 1947) Filed by registrar
Entered by Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/1 1947 at 3 20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/29 1947 to 4/1 1947 and that I last saw h 21 alive on 4/1 1947.

Immediate cause of death	Duration
Cardio Respiratory Failure	
Due to Intestinal Obstruction	
Due to Thrombosis Coronary	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Anthony Jones M. D.
Address Date signed

VS 150

G50268

BALTIMORE CITY HEALTH DEPARTMENT

4431 CERTIFICATE OF DEATH 93D

G50268 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St
(c) Hospital or institution: South Balto Gen Hosp. 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 920 S. Hanover St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Thelma M. Johns

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife James H. Johns
6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) Jan, 1902

8. AGE: Years	Months	Days	If less than one day
45	3		hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William P. Freeny
13. Birthplace Md.

MOTHER
14. Maiden Name Rayner
15. Birthplace Md.

16 (a) Informant Husband
(b) Address 920 S. Hanover St

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4/5/47 (month) (day) (year)
(c) Cemetery or crematory WOODLAWN
Location WOODLAWN, MD.

18 (a) Funeral director JOHN F. DENNY, INC
(b) Address 715 LIGHT ST

1947 APR 2 - (Stamped by Registrar) (b) Signature

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1947, at 7:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 31 1947 to Apr 1 1947, and that I last saw h[illegible] alive on Apr 1 1947

	Duration
Immediate cause of death Acute Congestive Heart Failure	1 day
Due to Hypertensive Cardio-vascular disease	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harold Hillon M. D.
Address Gen Balto Gen Hosp Date signed Apr 1, 47

X

MARGIN-RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50269 442.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G50269 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 423 N. Gilmor St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 -
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 423 N. Gilmor St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rebecca Clark

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Ferdinand

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10, 1883

8. AGE: Years 60 | Months — | Days 20 | If less than one day hr. min.

9. Birthplace Campbell C. Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Elijah Clark
13. Birthplace Campbell C. Va

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Henry A. Clark
(b) Address 423 N. Gilmor St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 2, 1947 (month) (day) (year)
(c) Cemetery or crematory Family Lot
Location Springs Mills, Va

18 (a) Funeral director Mrs. Maurice A. Holland
(b) Address 631 Druid Hill Ave

APR 2 - 1947 (Date rec'd by Local Reg.) (b) Funeral Home, Williamsburg, Va

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/30 1947 at 7 05 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1 19 47 to 3/30 19 47 and that I last saw h alive on 3/30 19 47

Immediate cause of death
Cerebral Hemorrhage
Due to Hypertension
Due to Chronic Nephritis

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. W. Heath M.D.
Address 426 N. Gilmor Date signed 4/1/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

G50270 491 CERTIFICATE OF DEATH 107 ✓ Registered No. G50270

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1027 Argyle Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1027 Argyle Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edith Brooks Hilson ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex Female | 5 Color or race Colored | 6 (c) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Edward

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 10, 1867

8. AGE: Years 80 | Months 2 | Days 20 | If less than one day hr. min.

9. Birthplace Lynchburg, Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Lindsay Gilbert

13. Birthplace Va

MOTHER 14. Maiden Name Fanny A. Lynch

15. Birthplace Va

16 (a) Informant Mrs. Mildred Ross

(b) Address 1027 Argyle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 2, 1947 (Month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore, Md.

18 (a) Funeral director Mrs. Chas. H. Stallard

(b) Address 1631 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Registrar, M. D.

APR 2 - 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/30/47 19 47 at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/17/47 to 5/30/47 and that I last saw h[illegible] alive on 5/29/47

Immediate cause of death Bronchial Pneumonia — Duration 3 days

Due to Influenza — Duration 2 days

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Ray Ellis M. D.

Address 921 Park Ave. Date signed 4/2/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G50271 442.1 131a V R-850871

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 606 E. 28th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 606 E. 28th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert Henry Jackson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4 Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Amanda

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 10, 1868

8. AGE: Years 79 | Months 1 | Days 19 | If less than one day hr. min.

9. Birthplace Caroline Co. Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Amanda Jackson
(b) Address 608 E. 28th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 2, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Thos. Chas. A. Stallard
(b) Address 1631 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

VS APR 2 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/29/47 at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1 1946 to Mar 29 1947 and that I last saw h[illegible] alive on Mar. 29 1947.

Immediate cause of death Cardio Renal Disease — Duration

Due to — June.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas A Stallard

Address 2329 Guilford Ave. Date signed Mar 31 1947

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50272 442.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G50272 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2075 Rockrose Ave.
(c) Hospital or institution: Ardleigh Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Pikesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Sudbrook Park
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FELIX LANGFELD

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widow

6 (b) Name of husband or wife: Margaret Langfeld
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1, 1871

8. AGE: Years	Months	Days	If less than one day
75	8 7	0 30	hr. min.

9. Birthplace Missouri, (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Wholesale Tailor'

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. J. C. Irish
(b) Address Sudbrook Pk. Pikesville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/2/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) APR 2 - 1947 reg. Hunting for Williams, Jr.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31, 1947, at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1940 to March 30 1947, and that I last saw him alive on March 31 1947.

Immediate cause of death: Cerebral accident — Duration

Due to: Generalized Arteriosclerosis

Due to: Chronic Interstitial Nephritis

Other Conditions: Chronic Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos J Abbott M. D.

Address Date signed

937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50273 420.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G50273 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2337 Druid Hill Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2337 Druid Hill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie E Stith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: Col

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Russell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 27, 1906

8. AGE: Years	Months	Days	If less than one day
40	6 5	5 3	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Edward Hicks
13. Birthplace Va.

MOTHER
14. Maiden Name Hattie Taylor
15. Birthplace Va.

16 (a) Informant Russell Stith
(b) Address 2337 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 2 47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location Balto County Md

18 (a) Funeral director Mrs Pittie O Elliott
(b) Address 1129 N. Caroline St

19 (a) (Date rec'd by registrar) (b)

APR 2 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 30 1947, at 7.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 2 1946 to Mar 30 1947 and that I last saw h[illegible] alive on Mar 30 1947

Immediate cause of death: Coronary Occlusion — Duration 3 Mo.
Due to
Due to
Other conditions: Mens Cancer uterus
Operations & Xrays
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury

23. Signature E A Richardson M. D.
Address 117 W. 76 St Date signed April 1 47

X

G50274 422.2 BALTIMORE CITY HEALTH DEPARTMENT G50274
CERTIFICATE OF DEATH 1937
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1232 Pennsylvania Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1232 Pennsylvania Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susie V. Taylor

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife James Taylor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 29, 1887

8. AGE: Years	Months	Days	If less than one day
60 59	2	1	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Robert F. Smith
13. Birthplace Md.

MOTHER
14. Maiden Name Annie V. Stewart
15. Birthplace Washington D. C.

16 (a) Informant James Taylor
(b) Address 1232 Pennsylvania Ave.

17 (a) Burial (b) Date thereof 4-3-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 1578 W. Biddle St.

APR 2 - 1947
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30, 1947, at 8P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-29- 1947 to 3-30- 1947 and that I last saw her alive on 3-30 1947

Immediate cause of death	Duration
Acute pulmonary edema	
Due to Chronic myocarditis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. L. Cornbrooks M. D.
Address 718 Dolphin St. Date signed 4-2-47

VS 150

G50275

420.0

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G.50275
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Parkwood & Dawns St.
(c) Hospital or institution: University Hosp. 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo 19 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Evans

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Col.

6 (a) Single, married, widowed or divorced.

6 (b) Name of husband or wife Frank Evans

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10, 1892

8. AGE: Years 54 | Months 11 | Days 19 | If less than one day hr. min.

9. Birthplace Jessup, Anne Arundel Co. Md
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Elisha Anderson
13. Birthplace Anne Arundel Co. Md

MOTHER
14. Maiden Name Caroline Jackson
15. Birthplace Anne Arundel Co. Md

16 (a) Informant William Anderson
(b) Address 408 N. Pine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 2, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 323 N. Schroeder St.

19 (a) Received APR 2 - 1947 (b) Registered by Registrar Kathryn Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1947, at 3:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 5 1947, to March 27 1947, and that I last saw h er alive on March 29 1947

Immediate cause of death	Duration
Cerebral Thrombosis	
Hemorrhage	
Due to Arteriosclerotic Heart disease	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles R Holmes

Address Univ. Hosp. Date signed 3/31/47

X

G50276

442.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G50276
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 650 Hoffman st
(c) Hospital or institution: Provident 17-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 650 Hoffman St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Sampson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: N
6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: Margaret Sampson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22 1893

8. AGE: Years 53 | Months 54 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name Edward Sampson.
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Turner.
15. Birthplace Md.

16 (a) Informant Mrs. Margaret Sampson.
(b) Address 650 W Hoffman St.

17 (a) Burial (b) Date thereof April 3, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary.
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder st

APR 2 - 1947 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/31 1947 at P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/31 1947 to 3/31 1947, and that I last saw h/s alive on 3/31 1947

Immediate cause of death Uremia — Duration

Due to Arteriosclerotic Hypertension — 10-12 yrs.

Sequence Cardio-Vascular Renal

Due to Disease — 4 mos.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature G J Bayard M.D.
Address Provident Hospital Date signed 3/31/47

X

G50277. 260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G50277.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1141 Cleveland St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 + 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1141 Cleveland Stl
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Willingham

3 (b) If veteran, name war	3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Married

6 (b) Name of husband or wife Charles A. Willingham
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30, 1875

8. AGE: Years	Months	Days	If less than one day
71	9	1	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name John Schnepke
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs Katherine Egley
(b) Address 6 S. Abington Ave.

17 (a) Burial (b) Date thereof 4/5/47.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Richie Highway, A.A. Co.

18 (a) Funeral director Friedrich A. Coffe
(b) Address 1700 W Lombard St

19 (a) [redacted]

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1st 1947, at 7 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 11 1945 to April 1 1947.
And that I last saw h[illegible] alive on March 27 1947.

Immediate cause of death	Duration
Arteriosclerotic + Hypertensive Cardiovascular Disease	
Due to	
Due to	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Albert Plunkett M.D.
[illegible] 2302 E Eager St Date signed 4/1/47

93D Schochat

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50278 490 BALTIMORE CITY HEALTH DEPARTMENT 108 Registered G50278

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1704 N. Montford Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1704 N. Montford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie E. Bell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 14 1879

8. AGE: Years 68 | Months | Days 16 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Emerson Drug Co

FATHER 12. Name Joseph F. Bell
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Laura V. Reynolds
15. Birthplace Balto Md

16 (a) Informant Mary F. Bell
(b) Address 1704 N. Montford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-2-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Frederick Ave

18 (a) Funeral director Ray C. Miller Inc
(b) Address 2437 E Oliver St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-19 1946 to 3/27 1947, and that I last saw her alive on 3/29 1947

Immediate cause of death Pneumonia Lobar — Duration

Due to Mal nutrition

Due to age

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. D. Franklin M. D.
Address Date signed

V S 150

4-2-1947 Huntington Williams, Mor

H. D. Franklin

G50279 991 E974

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V/164a

G50279

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 514 N Linwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 514 N. Linwood Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry B. Hoffman Hofmann

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-1013

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb-20-1894

8. AGE: Years	Months	Days	If less than one day
53	1	11	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Motorman

11. Industry or business Balto. Transit Co.

FATHER
12. Name Charles Hofmann
13. Birthplace Balto.

MOTHER
14. Maiden Name Ernestine Smith
15. Birthplace Akron Ohio

16 (a) Informant Ernestine Hofmann
(b) Address 514 N Linwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-3-47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director John D. Mulloy Sons
(b) Address 2435 E Oliver St

19 (a) APR 2 - 1947 (Date rec'd by registrar) (b) Huntington Hollins, Md. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1947, at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to strangulation

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-31-47 at 1:30 P.M.
(b) Where did injury occur? 514 N Linwood Ave
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Hanging around underclothes, ans

23. Signature Earl L Koons M.D.
Medical Examiner.
Date signed 4-1-47

G50280

BALTIMORE CITY HEALTH DEPARTMENT

CWKe109330 002

CERTIFICATE OF DEATH

13 B

Registered No. G50280

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution: Baltimore City Hospitals 13-1

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 Days

(e) Length of stay in Baltimore (yrs., mos., or days) 15 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2501 Madison Avenue (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Leonard Garner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widowed

6 (b) Name of husband or wife Adelaide (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19-1867

8. AGE: Years	Months	Days	If less than one day
80	0	12	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Samuel Garner

13. Birthplace ?

MOTHER

14. Maiden Name Julia Ann ?

15. Birthplace ?

16 (a) Informant Records-Balto. City Hospitals

(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/47 (month) (day) (year)

(c) Cemetery or crematory Family Lot

Location Lilian, Va

18 (a) Funeral director Mrs. George H. Stallard

(b) Address 1637 Druid Hill Ave

APR 2 - 1947 (Date rec'd by Registrar)

(b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 19 47 at 3:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mch. 21 19 47 to Mch. 31 19 47, and that I last saw h im alive on Mch. 31 19 47

Immediate cause of death: Pulmonary Tuberculosis, Miliary

	Duration
Due to	Unknown
Due to	
Other Conditions Generalized arteriosclerosis, Pulmonary Emphysema (Include pregnancy within 3 months of death)	Unknown

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Laurence Lee Jr. M.D.

Address Baltimore City Hosps Date signed 4-1-47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50281 491

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G50281

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3015 Fait ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John A. Peters

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-10-5875

4. Sex M | 5. Color or race W | 6 (a) Single, married, (widowed) or divorced.

6 (b) Name of husband or wife Daisy M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 17, 1880

8. AGE: Years 66 | Months 4 | Days 14 | If less than one day hr. min.

9. Birthplace W. Va (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER 12. Name James W. Peters
13. Birthplace W. Va

MOTHER 14. Maiden Name Molly Hott
15. Birthplace W. Va

16 (a) Informant Orville N. Peters
(b) Address 3721 Eccodale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/4/47 (month) (day) (year)

(c) Cemetery or crematory Mt Zion - Location Augusta W. Va

18 (a) Funeral director Howard M. Blight Jr
(b) Address 4914 Belair Road

19 (a) Date received 1947 (Local registrar) Huntington Williams M.D.

APR 2

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/1/47 19 , at 4:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/27 1947 to 4/1 1947 and that I last saw h.i.m alive on 3/31 1947

Immediate cause of death Cardio-Respiratory Failure — Duration

Due to Pneumonia

Due to Bronchopneumonia (Terminal)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Catherine J. Allen M.D.

Address St. Josephs Date signed 4/3/47

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G50282 151 46 B

Registered No. G50282

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 920 Warner
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 920 Warner St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie R. C. Dorsey

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Charles E. Dorsey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 23-1877

8. AGE: Years 70 | Months 2 | Days 8 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Samuel Ringgold
13. Birthplace Md

MOTHER
14. Maiden Name Sarah Brown
15. Birthplace Md

16 (a) Informant Ella Smith
(b) Address 920 Warner St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-4-47 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Jas. E. Sayus
(b) Address 942 Wolfe St

19 (a) (Date rec'd by registrar) (b) Registrar

APR 2 - 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1947, at 1:15 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 1/30/1947 to 3/31/1947 and that I last saw her alive on 3/31/1947

Immediate cause of death: Carcinoma of Stomach — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Ringgold M. D.

Address 601 N. Carrollton Ave signed 4/4/47

Huntington Williams, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50283 442.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G50283

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 911 S. Fremont
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 911 S. Fremont ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary King

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years 47 | Months | Days | If less than one day hr. min.

9. Birthplace Yorktown Va
(Town, county, and state)

10. Usual Occupation at Home

11. Industry or business

FATHER
12. Name Major Robinson
13. Birthplace Va

MOTHER
14. Maiden Name Elmire Walker
15. Birthplace Va

16 (a) Informant John Ramsey
(b) Address 911 S. Fremont ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-3-47 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director James A Adams
(b) Address 1142 Woodall St

19 (a) (Date received by registrar) APR 2 1947 (b) Registrar Huntington Williams, M.D.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1947, at 8:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 15 1947, to March 30 1947, and that I last saw h[illegible] alive on March 29 1947.

	Duration
Immediate cause of death: Respiratory Failure	
Due to: Hypertensive Cardio Vascular renal disease	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. Sherrod M.D.

Address 601 N. Monroe St. Date signed 4/1/47 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G50284 | 56 | 469 | Registered No. G50284

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Aves.
(c) Hospital or institution: St. Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 38
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore Woodlawn
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6823 Dogwood Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret L. Sutch

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: W. Clarence Sutch
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) August 25, ~~1891~~ 1901

8. AGE: Years 45 | Months 7 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore County, Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER: 12. Name William Reinhold
13. Birthplace Baltimore County Md.

MOTHER: 14. Maiden Name Maggie Sauter
15. Birthplace Baltimore County Md.

16 (a) Informant Mr. W. Clarence Sutch
(b) Address 6823 Dogwood Road, Woodlawn

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 3, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Olive Cemetery
Location Randallstown, Md.

18 (a) Funeral director Miller Lamonaco
(b) Address 4510 Liberty Heights Ave.

19 (a) (Date rec'd by reg.) APR 2 1947

VS

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/31 1947, at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/21 1947 to 3/31 1947, and that I last saw h[illegible] alive on 3/31 1947.

Immediate cause of death	Duration
(a) Respiratory Failure	
Due to Carcinoma Pancreas	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry W. Hollyer M. D.
Address 88 Upper Hosp Date signed 3-31-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C-0285 443.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

C50285 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 842 W. Baltimore Street
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 842 W. Baltimore Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME William J. Lang

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife:
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 25, 1884
8. AGE: Years 62 | Months 10 | Days 6 | If less than one day ... hr. ... min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Shirt Maker
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mr. Edwin C. Gibbons
(b) Address 5508 Carter Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 3 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director William J. Lee
(b) Address 824 N. Paul St.

19 (a) [illegible] Washington Williams M.D.
(Date received by registrar) (Registrar)

APR 2 1947

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 29 1947, to March 30 1947, and that I last saw h[illegible] alive on March 30 1947.

Immediate cause of death: Hemiplegia and Cerebral Hemorrhage — Duration: 7

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry Heinemann M. D.
Address 2617 Nicholson Date signed April 2, 47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50286 420.1 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 1940 G50286 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1145 E. Lombard St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 -
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1145 E. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Leppier

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Nellie Leppier

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 28th 1862

8. AGE: Years	Months	Days	If less than one day
85	1	1	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Paper Hanging

FATHER
12. Name (Unknown) Leppier
13. Birthplace "

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Nellie Leppier
(b) Address 1145 E Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/4/47 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel Md
Location Baltimore Md

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St Paul St.

19 (a) Date received by registrar APR 2 1947 (b) [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 29th 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 16 1947 to Mar 29 1947.
and that I last saw him alive on March 27 1947.

Immediate cause of death	Duration
Coronary Thrombosis	days
Due to Coronary Sclerosis	?
Due to Chr. Arteriosclerosis	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature [illegible] M. D.
Address [illegible] Date signed 3/31/47

G50287 341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G50287

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3038 Keswick Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and city town)
(a) Street No. 3038 Keswick Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James M Davis

3 (b) If veteran, name war
3 (c) Social Security Account No.
4 Sex: M
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Grace E Davis
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec 2. 1878
8. AGE: Years 68 | Months 3 | Days 29 | If less than one day hr. min.
9. Birthplace Frostburg Md (Town, county, and state)
10. Usual Occupation Moulder
11. Industry or business

FATHER
12. Name Wilhom L Davis
13. Birthplace Frostburg Md

MOTHER
14. Maiden Name Henrietta Boswell
15. Birthplace Va.

16 (a) Informant Grace E Davis
(b) Address 3038 Keswick Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/4/47 (month) (day) (year)
(c) Cemetery or crematory Savage
Location Savage Md

18 (a) Funeral director Wilhom L Davis
(b) Address 1217 E Pratt St

19 (a) 1947 (Date received by registrar) (b) Registered No.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 1 1947, at 4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/10 1947, to 3/31 1947, and that I last saw him alive on 3/31 1947.

Immediate cause of death: Cerebral Hem — Duration: 3 Days
Due to Arterio Sclerosis — 4 yrs
Due to
Other Conditions Epilepsy — Duration: about Life
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 2020 N. Charles Date signed 4/2/47 M. D.

X

G50288

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

813 E902 186a

G50288 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1033 N. Central Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1033 N. Central Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Selena Cole

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec-31-1863

8. AGE: Years	Months	Days	If less than one day
83	2	29	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Benjamin Cole
13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Harriet Jones
15. Birthplace Baltimore Md.

16 (a) Informant Margaret Butler
(b) Address 400 Laurel Court Baltimore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-3-1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Park
Location Balto, Maryland

18 (a) Funeral director Mrs. Ida Bailey
(b) Address 1421 Jefferson St

19 (a) Date received 1947 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar - 29 1947 at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1947 to Mar 29 1947 and that I last saw [illegible] alive on Mar 29th 1947

Immediate cause of death Cerebral Hemorrhage — Duration 3 Days

Due to Arteriosclerosis

Due to

Other Conditions fractured femur

Treated by Hospital - Surgery
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 10/1
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Mar 26, 47 5 P. M
(c) Where did injury occur? Baltimore (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work?
(e) Means of injury Fell down stairs at home

23. Signature Karl Traupel M. D.
Address 1623 E. N. Ave. Date signed 3-31-47

For Mrs. Helfrich by Howard D. Wiedefeld M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50289 443.1 BALTIMORE CITY HEALTH DEPARTMENT G50289
CERTIFICATE OF DEATH 1937 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd Calvert St.
(c) Hospital or institution: Univ.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Preston Apts. Preston (If rural give location) Guilford
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Lillie G. Graff.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fem.	White	Widow.

6 (b) Name of husband or wife George Graff
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-21-1872

8. AGE: Years	Months	Days	If less than one day
74	11	10	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation housewife.
11. Industry or business
12. FATHER Name Rufus Jordan.
13. Birthplace
14. MOTHER Maiden Name
15. Birthplace Woolford Family
16 (a) Informant Hospital
(b) Address Union Memorial
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr (month) (day) 1947 (year)
(c) Cemetery or crematory Green Mount
Location Balto Md
18 (a) Funeral director Henry W. Jenkins & Sons
(b) Address McCulloh & Richard Sts.
19 (a) (Date rec'd by registrar) (b) Registrar

APR 2 - 1947 Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-1 1947, at 8:20 AM
21. I certify that death occurred on the date above stated; that I attended deceased from 4-1 1947, to 4-1 1947, and that I last saw her alive on 4-1 47. 19

Immediate cause of death	Duration
Cerebro-vascular accident (hemorrhage)	
Due to Hypertension cvd	
Due to Chr. & gen. arterio sclerosis.	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Edward H. Jones Jr. M. D.
Address U. M. H. Date signed 4-1-47

33rd. Calvert St. X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50290 193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54a

Registered No. G50290

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 75
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1323 Eutaw Place (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Thomas S. Janney

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Wid

6 (b) Name of husband or wife 2
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 6, 1870

8. AGE: Years	Months	Days	If less than one day
76	2	25	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired coal dealer
11. Industry or business

FATHER
12. Name Johns Hopkins Janney
13. Birthplace Maryland

MOTHER
14. Maiden Name Caroline Symington
15. Birthplace Maryland

16 (a) Informant Mrs Wm C Hoffman
(b) Address Owings Mills P.O.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 3 1947 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Henry W. Sankey Sons Co
(b) Address McCulloh & Orchard Sts

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1947, at 5.04 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1947, to April 1 1947, and that I last saw him alive on April 1 1947.

Immediate cause of death	Duration
Cerebral Thrombosis	4 mo
Due to Generalized arteriosclerosis	yrs
Due to	over
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Brain tumor

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman R. Freeman M.D.
Address Union Memorial Hosp Date signed April 1/47

VS 150 APR 2 - 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G50291 260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G50291 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 533 WINSTON AVE.
(c) Hospital or institution: 27
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 54

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 533 Winston Ave (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** MARY JANIONIS (YANION)

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced W

6 (b) Name of husband or wife MARTIN YANION
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 77 | Months + | Days — | If less than one day ... hr. ... min.

9. Birthplace LITHUANIA (Town, county, and state)
10. Usual Occupation RETIRED
11. Industry or business

FATHER
12. Name ADAM KLIBAS
13. Birthplace LITHUANIA

MOTHER
14. Maiden Name ELIZ. BARAUSKAS
15. Birthplace LITHUANIA

16 (a) Informant EMILIJA RAILA
(b) Address 533 WINSTON AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4-3-47 (month) (day) (year)
(c) Cemetery or crematory WESTERN
Location EDMUNDSON AVE

18 (a) Funeral director Charles W. Kachanoski
(b) Address 103 MC HENRY ST.

APR 2 1947 (Date) (Registrar) Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR. 31 1947, at 9-15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-27- 1947, to 3-31 1947, and that I last saw her alive on 3-31 1947.

Immediate cause of death	Duration
(a) Chronic Myocardial Disease	? 5 yrs -
Due to	
Due to	
Other Conditions. Diabetes Mellitus	? 2 YR.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Hattaga M. D.
Address 5217 York Rd Date signed 3/31/47

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50292

443.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G50292

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or county limits, write RURAL and give county)
(d) Street No. 6800 Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Angie Crowell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Clinton Crowell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 17, 1880

8. AGE: Years 67 | Months 2 | Days 13 14 | If less than one day hr. min.

9. Birthplace Ind. (Town, county, and state)

10. Usual Occupation H. W.

11. Industry or business

FATHER 12. Name James H. Howard
13. Birthplace Ind.

MOTHER 14. Maiden Name Martha Powell
15. Birthplace Ind.

16 (a) Informant Arthur Fraidin
(b) Address 4009 Liberty Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/2/47 (month) (day) (year)

(c) Cemetery or crematory Lorraine Pk.
Location Woodlawn - Md

18 (a) Funeral director Happy H. Mitzke
(b) Address 401 E Monument Ave

19 (a) Filed 1947 (b)

APR 2 1947

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1947, at 10:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Hypertension Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William F. Kelly M.D. Medical Examiner.
Date signed April 1, 1947

X

G50293
39850 156

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 469

G50293
Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 927 De Sota Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Wheeler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife William Wheeler
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 8-14-79

8. AGE: Years	Months	Days	If less than one day
67	7	17	....hr. ....min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Edward Brown
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Gunning
15. Birthplace Md.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof April 5 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3501 Frederick Rd
18 (a) Funeral director Harry A Stifler
(b) Address 410 Edmondson Ave
19 (a) (b)
(Date received by registrar) Registrar

APR 2 1947
1S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April - 1 - 1947 at 2 35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-27-1947 to 4-1-1947 and that I last saw her alive on 4-1-1947

Immediate cause of death Hematemesis — Duration 2 hours
Due to Carcinoma ulcerating stomach
Due to Primary Carcinoma of Head of Pancreas — Duration 10 mos
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 9-28-46
Major findings of operation: Carcinoma of pancreas
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edmund S Delphia
Address Johns Hopkins Hospital Date signed 4-1-47 M. D.

X

G50294

BALTIMORE CITY HEALTH DEPARTMENT

443.1 CERTIFICATE OF DEATH 97

G50294
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2002 E. Pratt St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 48 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2002 E. PRATT ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME SARAH JACOBSON

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: FEMALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: MICHAEL S.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 63 Months Days If less than one day hr. min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business

FATHER 12. Name

FATHER 13. Birthplace RUSSIA

MOTHER 14. Maiden Name JENNIE

MOTHER 15. Birthplace RUSSIA

16 (a) Informant HUSBAND

(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4-3-47 (month) (day) (year)

(c) Cemetery or crematory MICKRO KODESH

Location PHIL RD. & BOWLEYS LANE

18 (a) Funeral director JACK LEWIS INC

(b) Address 1439 E. BALTO. ST

19 (a) 1947 Filed by registrar Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-1- 1947, at 1:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 19, 1945 to 4/1/1947 and that I last saw h[illegible] alive on 4/1/1947

Immediate cause of death: Complete Heart Block — Duration 1 year

Due to Arteriosclerosis with hypertension 6 years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M B Levine M.D.

Address 211 W. Monument St Date signed 4/4/47

VS 150

X

G50295 422. BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH X 937 (G50295)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: Lenwerth Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County Baltimore
(c) City or town Catonsville Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. Della Ave 428
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W Cole

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Mary C Cole
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 1850

8. AGE: Years	Months	Days	If less than one day
96 97	11		hr. min.

9. Birthplace Maryland.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Alfred Cole
13. Birthplace Md.

MOTHER
14. Maiden Name Janey Cole
15. Birthplace Md.

16 (a) Informant Uriah Cole
(b) Address Catonsville Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-2-47 (month) (day) (year)
(c) Cemetery or crematory Mt Gilboa
Location Della Md

18 (a) Funeral director J C Heyenbottom
(b) Address Ellicott City Md

APR 2 - 1947 (Date rec'd by registrar) (b) Registrar

VS 150

Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-31 1947, at 6.40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-21 1947 to 3-31 1947; and that I last saw h[illegible] alive on 6.46 1947 3-31-47

Immediate cause of death	Duration
Acute Pulmonary Edema	
Due to Arteriosclerotic	
C V D Disease	
Due to Old Age	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph L Clark M. D.
Address Lenwerth Hospital Date signed 3-31-47

X

BALTIMORE CITY HEALTH DEPARTMENT

G50296 420.1 **CERTIFICATE OF DEATH** 194a

Registered No. G50296

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: D-A

(a) Baltimore City, Maryland

(b) Street address 2602 E. Monument St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore City

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2602 E. Monument St

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Vincent C. Piraino, Piraino

3 (b) If veteran, name war: I War

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~Husband~~ wife: Jennie Piraino

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 23rd 1890

8. AGE: Years ~~Under 1 year~~ 56 | Months 4 | Days 9 8 | If less than one day hr. min.

9. Birthplace Cefalu Italy (Town, county, and state)

10. Usual Occupation Barber

11. Industry or business Self Employed

FATHER

12. Name Emanuele Piraino

13. Birthplace Italy

MOTHER

14. Maiden Name Giuseppina Messina

15. Birthplace Italy

16 (a) Informant Jennie Piraino (Wife)

(b) Address 2602 E.Monument St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 5/1947 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Rd. Baltimore Md.

18 (a) Funeral director Harold Dallas Wise

Address 52 N.Morley St.

19 (a) APR 2 - 1947 (Date rec'd by registrar) (b) [illegible] M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/1 1947, at 3:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature C. L. Schweich M.D. Medical Examiner.

Date signed 4/1/47

G50297 804 E810

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1701 C

Registered No. G50297

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State W Va. (b) County.....
(c) City or town Moorefield (If outside city or town limits, write RURAL and give town)
(d) Street No..... (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Elwood N. Turley

3 (b) If veteran, name war

3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Rosana Turley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 6 (1913)

8. AGE: Years	Months	Days	If less than one day
(33) 35	3	26	hr. min.

9. Birthplace Hampshire West Va.
(Town, county, and state)

10. Usual Occupation Lumberman
11. Industry or business J. Narick Co.

FATHER
12. Name Stanley H. Turley
13. Birthplace West Va.

MOTHER
14. Maiden Name Bertha Orndoff
15. Birthplace West Va

16 (a) Informant Mr Stanley N. Turley
(b) Address 102 Spring St Petersburg W. Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/6/47 (month) (day) (year)
(c) Cemetery or crematory Moorefield Va Cemetery
Location Moorefield West Va

18 (a) Funeral director Milton Schilling
(b) Address 3914 Hanover St

19 (a) (Date received by registrar) Burlington Williams M.D.

APR 2 1947

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1947, at 3 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Fractured skull
Intracranial hemorrhage
Due to Fractured ribs.

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 23/2

(a) Date of injury 4-1-47 at 2:30 P M.
(b) Where did injury occur? Hanover & Potapsco Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury. Pedestrian struck by auto

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 4-2-47

G50298

AB-99928 443.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G50298 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr- 0mos- 9days
(e) Length of stay in Baltimore (yrs., mos., or days) 76yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. No Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Hebron

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Widowed

6 (b) Name of husband or wife Wilhemina (D
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30- 1865

8. AGE: Years	Months	Days	If less than one day
81	8	23	hr. min.

9. Birthplace Annapolis, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Leroy Hebron or Levi Hebron-or-Leur Hebron
13. Birthplace Maryland

MOTHER 14. Maiden Name Dallas Strickland-or Mina Strickland
15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospita
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School APR1 1947

18 (a) Funeral director Commissioner of Health
(b) Address
APR 2 1947 (Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1947, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-14- 1946 to 3-23- 1947, and that I last saw him alive on 3-23- 1947

Immediate cause of death — Duration
Bronchopneumonia — 3 weeks
Due to
Due to
Other Conditions Hypertension
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. Russell Huff M. D.
Address Baltimore City Hosp. Date signed 3/31/47

VS 150

107

G50299 760.5 BALTIMORE CITY HEALTH DEPARTMENT G50299

Ward # 74268 CERTIFICATE OF DEATH 1600 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave 16
(c) Hospital or institution West Balto Gen Hosp.
(d) Length of stay in hospital or inst. (yr., mos., or days) 5
(e) Length of stay in Baltimore (yr., mos., or days) 5

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balto 21 (If outside city or town limits, write RURAL and give town)
(d) Street No. 604 N Stuart Ave (If rural give location)
(e) Citizen of foreign country? / (Yes or No)
If yes, name country

3 (a) FULL NAME Ronald Speckhals

3 (b) If veteran, name war none | 3 (c) Social Security Account No. none

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. /

6 (b) Name of husband or wife /
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25 1947

8. AGE: Years / Months / Days 5d If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Newborn None

11. Industry or business

FATHER 12. Name Ronald Speckhals
13. Birthplace Penna

MOTHER 14. Maiden Name Dolores Frank
15. Birthplace Baltimore

16 (a) Informant
(b) Address 604 N Stuart Ave 21

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School APR1 1947

18 (a) Funeral director Commissioner of Health
(b) Address
APR 2 1947 (Date rec'd by registrar) Hilary J. Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1947 at 2 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-25 1947 to 3-29 1947 and that I last saw him alive on 3-29 1947.

Immediate cause of death	Duration
Subarachnoid Hemorrhage	
Due to Prematurity	
Due to:	
Other Conditions Atelectasis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation Subarachnoid hem @ atelectasis @ Meckel's diverticulum
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. D. Trapnell M. D.
Address W. Balto Gen Hosp Date signed 3-31

VS 150

G50300 Birth Certificate

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G50300 Registered No. 9-075175 996 X 159

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Winchester Virginia (If outside city or town limits, write RURAL and give town)
(d) Street No. Valley Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Miller

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex male
5. Color or race white
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/29/47

8. AGE: Years | Months | Days | If less than one day: 2 hr. 15 min.

9. Birthplace Balto. 31 Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Lepat. Miller
13. Birthplace Va.

MOTHER
14. Maiden Name Phyllis Heine
15. Birthplace Va.

16 (a) Informant Mother
(b) Address Winchester, Va.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School APR1 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 APR 2 1947 (Date rec'd by registrar) (b) [illegible] Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/29/47 19 , at 3:45 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 3/29/47 to 3/29/47 19 , and that I last saw h[illegible] alive on 3/29/47 19

Immediate cause of death: Respiratory Failure — Duration
Due to: Premature 8 mo.
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph D. Patterson
Address Church Home & Hosp. Date signed 3/31/47 M. D.

X

G50301 456

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 99

G50301 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 517 N Shepard St 31
(c) Hospital or institution:
7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto 5
(If outside city or town limits, write RURAL and give town)
(d) Street No. 517 N Shepard St - 5
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Anton Rezac

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-03-9003

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 14 Oct 02

8. AGE: Years	Months	Days	If less than one day
44	5	17	hr. min.

9. Birthplace Kolin Czechoslovakia
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Distillery

FATHER
12. Name Anton Rezac
13. Birthplace Czech

MOTHER
14. Maiden Name Elizabeth Novak
15. Birthplace Czech

16 (a) Informant Mrs. Barbara Stepan - sister
(b) Address 700 N. Linwood Avenue

17 (a) Burial (b) Date thereof 4/3/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Horner's Lane, Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

(a) Date received (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 31 Mar 1947, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 29 Mar 1947 to 31 Mar 1947 and that I last saw h[illegible] alive on 31 Mar 1947

Immediate cause of death Endocarditis
abdominal

Duration
un-
known

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M.D.
Address 2214 Gaylord St Date signed 3 April 1947

V.S. 153

X

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The write the causes of death clearly and legibly. Physicians: please write PLAINLY, WITH UNFADING INK. correct age is especially important.

BALTIMORE CITY HEALTH DEPARTMENT

G50302 4431 **CERTIFICATE OF DEATH** 937

Registered No. G50302

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 dy.
(e) Length of stay in Baltimore (yrs., mos., or days) 6 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 427 N. Kenwood
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles F Leimbach

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of ~~husband~~ or wife: Mary Cosgrove Leimbach

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-15-84

8. AGE: Years 64 | Months 9 | Days 16 | If less than one day hr. min.

9. Birthplace Md.
(town, county, and state)

10. Usual Occupation Checker

11. Industry or business

FATHER 12. Name August Leimbach

13. Birthplace Germany

MOTHER 14. Maiden Name Elizabeth Webster

15. Birthplace Germany

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 4/5/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd. Balto. Md.

18 (a) Funeral director Charles E. Schimunek

(b) Address 2601-03 E. Madison Street

19 (a) (Signature of person who filed by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 19 47 at 2 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 19 47 to Apr 1 19 47 and that I last saw him alive on April 1 19 47

Immediate cause of death: CEREBRAL HEMORRHAGE — Duration: 8 HRS

Due to: HYPERTENSIVE CARDIOVASCULAR DISEASE — YEARS

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Maxwell Williams, MD

Address Johns Hopkins Hosp. Date signed 4-1-47 M. D.

Birth Certificate

G50303

D-75812 760.5

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V160a

G50303 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: University Hosp.
(c) Hospital or institution: Redwood & Green Sts.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits write RURAL and give town)
(d) Street No. 2601 Guilford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arlene Barbara Baum

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	S.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/23/47

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace Univ. Hosp., Balt., Md. (Town, county, and state)
10. Usual Occupation Infant.
11. Industry or business

FATHER
12. Name Melvin Herbert Baum
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Shirley Ann Lahr
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Shirley Baum
(b) Address 2601 Guilford Ave. Balt.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/2/47 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Cem. Co
Location Baltimore & Pimlico Rds.

18 (a) Funeral director J. Aarons Co
(b) Address 253 W. Baltimore St.

19 (a) (b) Date received by registrar

APR 2 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1947 at 11:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/30 1947 to 4/1 1947, and that I last saw her alive on 4/1 1947.

Immediate cause of death Respiratory failure — Duration —

Due to: a Congenital cardiac abnormality

Due to: b Intracranial hemorrhage.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. W. Lyerton
Address Univ. Hosp. Date signed 4/4/47 M D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C5D304 2620 61

✓ C5D304 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4- 2- 19-
(e) Length of stay in Baltimore (yrs., mos., or days) 23 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3038 Pinewood Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Slawson

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-05-3282

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Divorced
6 (b) Name of husband or wife: Alice
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 7-1877
8. AGE: Years 69 | Months 9 | Days 25 | If less than one day hr. min.
9. Birthplace New York (Town, county, and state)
10. Usual Occupation
11. Industry or business General Chemical Co.

FATHER
12. Name Silas Slawson
13. Birthplace New York

MOTHER
14. Maiden Name Mary Wright
15. Birthplace New York

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4/2/47 (month) (day) (year)
(c) Cemetery Presb. Cemetery
Location Mahopac, N. Y.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md.

APR 2 - 1947 (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1947, at 1:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 15 1943 to Apr. 2 1947, and that I last saw him alive on Apr. 2 1947.

Immediate cause of death: Respiratory Failure — Duration
Due to: Cerebral Thrombosis
Due to:
Other Conditions: Diabetes Mellitus
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None performed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm R Hartshorne M. D.
Address Balto. City Hosp. Date signed 4-2-47

VS 150

Huntington Williams, M.D.

83B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50305 170

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. G50305

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 34 days
(e) Length of stay in Baltimore (yrs., mos., or days) 34 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Frederick
(c) City or town Walkersville
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH NICODEMUS

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female.	white	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 22 1874

8. AGE: Years	Months	Days	If less than one day
50	9	11 10	hr. min.

9. Birthplace Walkersville Frederick, Md.
(Town, county, and state)
10. Usual Occupation Book Keeper
11. Industry or business

FATHER
12. Name John D. Nicodemus
13. Birthplace Walkersville, Md.

MOTHER
14. Maiden Name Mary A. Kelley
15. Birthplace Walkersville Md.

16 (a) Informant Mrs. John V. Nicodemus
(b) Address Walkersville Maryland

17 (a) Burial (b) Date thereof April 5 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick City

18 (a) Funeral director G. F. Baylon
(b) Address Walkersville

APR 3 1947
(Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1947, at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1947 to April 3 1947 and that I last saw h.. alive on April 2 1947.

Immediate cause of death Respiratory failure

	Duration
Due to Metastatic carcinoma from carcinoma of right breast.	
Other Conditions Severe anemia	

(Include pregnancy within 3 months of death)
Date of operation October 1946
Major findings of operation: Carcinoma of right breast.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard G. Martin M.D.
Address Maryland Gen. Hosp. Date signed 4-3-47 M. D.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G50306 Registered No. G50306

G50306 BCHD 34114 204 74a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 819 Fairmount Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Woodson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1 10/9/45

8. AGE: Years 1 Months 5 Days 23 If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Louis Woodson
13. Birthplace Md.

MOTHER 14. Maiden Name Doris Anderson
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/5/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill, Md.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) APR 2 1947 (Date received by registrar) (b) Registrar's signature Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1, 1947 at 1:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 8 1947 to Apr. 1 1947, and that I last saw him alive on Apr. 1 1947.

Immediate cause of death Pneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. Childs M. D.

Address Johns Hopkins Hosp. Date signed 4-1-47

X

G50307

422.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No. G50307

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5809 Reisterstown Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ~~Baltimore~~
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5809 Reisterstown Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CHARLES C. REISINGER

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Maria Lulu Reisinger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1862

8. AGE: Years	Months	Days	If less than one day
84	9	21	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name George Reisinger
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Hanna Toft
15. Birthplace England

16 (a) Informant Mrs. Wm. B. O'Neil
(b) Address 5809 Reisterstown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/4/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

APR 3 1947 (Date rec'd by local reg. or subreg.) (b) Huntingtown, Md.

MEDICAL CERTIFICATION A

20. DATE OF DEATH April 1, 1947 at 11:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1946 to April 1 1947 and that I last saw him alive on 3-31-1947

Immediate cause of death Arterio Sclerosis
Due to Cerebral Hemorrhage
Due to Age
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
unknown

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature T. B. Emmons M. D.
Address 7201 York Rd Date signed 4-2-47

VS 150

X

G50308 420.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G50308

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1723 Gorsuch Ave.
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days) ////////
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1723 Gorsuch Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Grandon Clay Johnson

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. 213-05-3598

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bertha M. Johnson
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1887

8. AGE: Years 60 | Months 1 | Days 19 | If less than one day ..... hr. ..... min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Checker
11. Industry or business American Oil Co.

FATHER
12. Name Harry Clay Johnson
13. Birthplace Virginia

MOTHER
14. Maiden Name Harriett Kendall
15. Birthplace Virginia

16 (a) Informant Mrs. Bertha M. Johnson
(b) Address 1723 Gorsuch Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 3, 1947 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial
Location Taylor Ave. Baltimore County

18 (a) Funeral director Henry H. Sander & Sons Inc.
(b) Address North Ave. & Broadway

19 APR 3 1947 (b) (Registrar) [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31, 1947, at 7:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946 to Mar 31 1947 and that I last saw h[illegible] alive on Mar 31 1947

Immediate cause of death Congestive Cardiac failure — Duration .....
Due to Decentralized Coronary arteriosclerosis — Duration .....
Due to ..... — Duration .....
Other Conditions ..... — Duration .....
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas J. Brennan
Address 5217 Harford Road Date signed 4-2-47 (M. D.)

X

G50309

183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

Registered No. G50309

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution: Elmhurst Nursing Home 9-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 705 Gorsuch Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY F. WOOD

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	single

6 (b) Name of husband or wife - - -
6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) Sept. 14. 1838

8. AGE: Years	Months	Days	If less than one day
78	6	17	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Seamstress
11. Industry or business

FATHER
12. Name Charles H. Wood
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Welthen A. Wood
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Harvey Wood
(b) Address 1704 N. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 3. 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore Md.

18 (a) Funeral director HENRY SANDER & SONS. INC.
(b) Address Baltimore Md.

APR 3 1947 (Date rec'd by Registrar) (Registrar) Washington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 1. 1947 at 10.00 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1946 to April 1 1947 and that I last saw her alive on 3/31/47 1947

Immediate cause of death: Cancerous ulcer of Uterus

Due to	Duration
with metastasis	7
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos. J. Gaughan
Address 2007 E. Fayette St. Date signed 4/4/47

X

G50310 423.1 BALTIMORE CITY HEALTH DEPARTMENT G50310

CERTIFICATE OF DEATH 937

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2562 Frederick Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2562 Frederick Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Elizabeth Kuemmert

3 (b) If veteran, name war None | (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Joseph A. Kuemmert | 6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) October 15, 1862

8. AGE: Years	Months	Days	If less than one day
84	5	18	hr. min.

9. Birthplace Balto. County, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Joseph Walter
13. Birthplace France

MOTHER
14. Maiden Name Catherine Eichelmann
15. Birthplace Maryland

16 (a) Informant Mary Theresa Goldman
(b) Address 2562 Frederick Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-5-47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Maryland

18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Ave.

19 (a) (Date received) APR 3 1947 (Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2, 1947, at 6:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 25 1947 to April 2 1947 and that I last saw h— alive April 2 1947.

Immediate cause of death: Chronic Myocarditis

Due to Arteriosclerosis

Due to old age

Other Conditions

Duration: 4 yrs. 15 yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hazel Lachman
Address 2122 Callow Ave Date signed April 3, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G50311 342 $3B ✓ Registered No. G50311

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring Ave
(c) Hospital or institution: Levendale
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3808 Woodhaven Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME NATHAN BLOCK

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed or divorced: Widowed

6 (b) Name of husband or wife: Fanny

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years: 80 | Months | Days | If less than one day: hr. min.

9. Birthplace: Lith (Town or county and state)

10. Usual Occupation: retired

11. Industry or business

FATHER
12. Name unknown
13. Birthplace Lith

MOTHER
14. Maiden Name unknown
15. Birthplace Lith

16 (a) Informant: David L. Block
(b) Address: 3828 Millstery Rd Ph Park

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-3-47 (month) (day) (year)
(c) Cemetery or crematory
Location: Hebrew Herring Law

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 1417 E Baltimore St

19 (a) (Date rec'd by registrar) (b) Registrar

APR 3 19 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2, 1947, at 12 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-23 1946 to 4-2 1947 and that I last saw h[illegible] alive on 4-2 1947.

Immediate cause of death: cerebral thrombosis — Duration:

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Henry Nagel

Address: Levindale Home Date signed 4-2-47

X

G50312 -- 422.2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

Registered No. G50312

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 822 McCabe Ave
(c) Hospital or institution: 27

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 822 McCabe Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jane K. Lavery.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Edward Lavery
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1860

8. AGE: Years	Months	Days	If less than one day
86	10	21	hr. min.

9. Birthplace Ireland. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER 12. Name Bernard Kennedy.
13. Birthplace Ireland.

MOTHER 14. Maiden Name Ellen J. Wilson.
15. Birthplace Ireland.

16 (a) Informant Miss. Mary Lavery.
(b) Address 822 McCabe Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 5/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road.

18 (a) Funeral director Chenoweth & Donovan.
(b) Address 3615 17 Chestnut Ave.

19 APR 2 1947 (Date rec'd by Reg.) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH April 2, 1947 at 7.25 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1947 to April 2 1947 and that I last saw him alive on April 1 1947

Immediate cause of death

Duration

Due to Myocardial Infarction

Due to Cerebral Accident

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature H. H. Smith, M. D.
Address 3429 Chestnut Ave. Date signed April 2-47

X

G50313 180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G50313 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp. 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 806 Berry St
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Maggie J. Falls

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: wh.

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: HERBERT FALLS.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-16-1889

8. AGE: Years 58 | Months | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore - Md.
(Town, county, and state)

10. Usual Occupation Weaver

11. Industry or business

FATHER
12. Name Thomas F Ruby
13. Birthplace Maryland

MOTHER
14. Maiden Name Lottie Arnold
15. Birthplace ?

16 (a) Informant Mrs Martha Ruby
(b) Address 2945 Keswick Rd-City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 3/47 (month) (day) (year)

(c) Cemetery or crematory St. Marys
Location Hampden

18 (a) Funeral director Thomas H Donovan
(b) Address 3615-17 Chestnut Terrace

19 APR 3 1947 (Date rec'd by local reg.) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar - 31 - 1947, at 2 00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar - 31 - 1947, to Mar - 31 - 1947, and that I last saw her alive on Mar - 31 - 1947.

Immediate cause of death	Duration
Carcinoma of Cervix	6 mos
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George F Schlesinger M. D.
Address 11 W. H. Date signed 3/31/47

G50314 151

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G50314

CERTIFICATE OF DEATH 46 12

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 Caroline St.
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Glendale, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 206 Ashwood Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Conan M. Coats

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Edward Coats
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12 1876

8. AGE: Years	Months	Days	If less than one day
71	9	18	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Franklin Fisher
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Boose
15. Birthplace Md.

16 (a) Informant Mrs Carroll Hobbs
(b) Address 206 Ashwood Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 2, 1947 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Hampden

18 (a) Funeral director C. Chenault Hartman
(b) Address 2645 N. Charles St.

APR 3 1947 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1947, at 6.20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 29 1947 to Mar 30 1947 and that I last saw her alive on March 30 1947.

Immediate cause of death	Duration
Cardiac - Respiratory failure.	
Due to Uterine hemorrhage	
Due to Possible Malignancy	
Other Conditions of Stomach	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John B Wells M.D.
Address 6 E Jos Hosp Date signed Mar 30 1947

M. D.

X

G50315 466

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 111a

Registered No. G50315

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 306 East 22nd Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 306 East 22nd Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET SCHAFER

3 (b) If veteran, name war ---
3 (c) Social Security Account No. ---

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1867
8. AGE: Years 80 Months Days If less than one day hr. min.
9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Ath Home
11. Industry or business

FATHER
12. Name Michael Murray
13. Birthplace Ireland

MOTHER
14. Maiden Name Francis Wallace
15. Birthplace Ireland

16 (a) Informant Mrs. Jos. Deming
(b) Address 306 East 22nd Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/5/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location City

18 (a) Funeral director WIEDEFELD AND SON
(b) Address GREENMOUNT AVE & 22ND

APR 3 1947 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2nd 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 31 1947 to Apr 2 1947, and that I last saw h[illegible] alive on Mar. 31 1947.

Immediate cause of death	Duration
Pulmonary embolism	Instan.
Due to Congestive heart failure & Thrombosis of aorta of	1 yr. 1 mo.
Due to hyp.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robt. B. Taylor M.D. M. D.
Address Medical Arts Bldg. Date signed 4/3/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50316 820 E900

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registration No. G50316

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Long.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1810 N. Fayette St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MICHELINA (Mary) Spinnicchia

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife Alfio Spinnicchia
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) July 14 1889

8. AGE: Years	Months	Days	If less than one day
57	8	18	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Forte
13. Birthplace Italy

MOTHER
14. Maiden Name Unknown
15. Birthplace Italy

16 (a) Informant Alfio Spinnicchia
(b) Address 1810 N. Fayette St.

17 (a) Burial (b) Date thereof April 7, 1942
(Burial, cremation, or removal) (Month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director George A. Farley
(b) Address Baltimore & Fayette Sts

19 (a) (Date rec'd by registrar) (b)

APR 8 1942

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1, 1942, at 3:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 26, 1942, to April 1, 1942, and that I last saw her alive on April 1, 1942.

Immediate cause of death	Duration
Cardiac failure	
Due to Arteriosclerotic heart disease	
Due to Generalized arteriosclerosis	
Other Conditions Diabetes mellitus, uremia; C.V. accident; fracture at hip	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 20/1
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Mar. 26 1942 at 11 2½ M
(c) Where did injury occur? Baltimore (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? no
(e) Means of injury Fall down steps

23. Signature Sidney Green M. D.
Address Sinai Hospital Date signed 4/6/42

George A. Merrill M.D.

G50347 Birth Certificate ↗776 ✓ G50347

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2013 N. Calvert St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby girl Demostes

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4 1 42

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Warren Demostes
13. Birthplace West Va.

MOTHER
14. Maiden Name Carla Elbin
15. Birthplace West Va.

16 (a) Informant Warren Demostes
(b) Address 2013 N. Calvert St

17 (a) Burial (b) Date thereof 4/3/42
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore

18 (a) Funeral director George A Farley
(b) Address Guilford & Fayette Sts

19 (a) Rec'd by (Registrar) (b) Entered by Registrar

APR 3 1942

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/2 1942, at 4:15 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1 1942, to 4/2 1942, and that I last saw her alive on 4/2 1942.

Immediate cause of death	Duration
Resp failure	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature August Keil M. D.
Address Mercy Hosp. Date signed 4/2/42

X

G50318 341 4435 BALTIMORE CITY HEALTH DEPARTMENT ✓ Registered No. G50318

CERTIFICATE OF DEATH 83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1610 Ashburton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1610 Ashburton St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles C. Fouts

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 214-54-7173
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Elizabeth M. Fouts
6 (c) If alive, give age 66 years
7. Birth date of deceased (mo., day, yr.) October 31-1870
8. AGE: Years 76 | Months 5 | Days 1 | If less than one day ____ hr. ____ min.
9. Birthplace Indiana (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Timothy Fouts
13. Birthplace Va

MOTHER
14. Maiden Name Margaret Hoffman
15. Birthplace Va

16 (a) Informant Elizabeth M. Fouts
(b) Address 1610 Ashburton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 5-1947 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem Park
Location Balt Cr B.M. Walter
18 (a) Funeral director
(b) Address 220 W. Stricker St
19 (a) (Date rec'd by registrar) APR 3 1947 Registrar

VS

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1947, at 9 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1st 1946, to Apr 1st 1947, and that I last saw h. alive on Apr 1st 1947.

Immediate cause of death	Duration
Uremia & [redacted] of prostate	
Due to Arteriosclerosis	
Due to Hypertension	
Other Conditions Senility	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M Paul Boyle, M.D.
Address 410 Medical Arts Bldg Date signed 4/3/47

Huntington Williams, M.D.

X

PLEASE WRITE PLAINLY. WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G50319 H20.1 94a

Registered No. G50319

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1504 N. Patterson Park Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1504 N. Patterson Pk. Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Caesar Krauss

3 (b) If veteran, name war: W.W. I
3 (c) Social Security Account No. 215-03-3706

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Hattie Krauss
6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) April 2, 1889

8. AGE: Years 58 | Months 0 | Days 0 | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation
11. Industry or business Continental Can Co.

FATHER
12. Name Ludwig Krauss
13. Birthplace Russia

MOTHER
14. Maiden Name Catherine Schuss
15. Birthplace Russia

16 (a) Informant Hattie Krauss
(b) Address 1504 N. Patterson Pk. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/5/47 (month) (day) (year)
(c) Cemetery or crematory Balto. National Cem.
Location Frederick Ave.

18 (a) Funeral director John C. Milby Inc.
(b) Address 243 E. Oliver St.

19 (a) (Date received by registrar) 1947 (b) Registrar

APR 3 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 April 1947, at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 April 1946 to 2 April 1947 and that I last saw h. liv. alive on 2 April 1947

Immediate cause of death: Coronary Thrombosis

Due to: Arteriosclerosis, generalized

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration: Approximately 15 months

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard Fassl M.D.

Address 1513 N. Milton Ave. Date signed 3 April 1947

X

G50320

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

002 13 B

G50320 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Light Street
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mos
(e) Length of stay in Baltimore (yrs., mos., or days) (?)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1519 Locust St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank ZAWITOSKI Sr

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-12-5690

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Josephine
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Moulder
11. Industry or business Kennedy Foundry

FATHER
12. Name Case
13. Birthplace Poland

MOTHER
14. Maiden Name
15. Birthplace Poland

16 (a) Informant Josephine
(b) Address 1519 Locust St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-5-47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A. A. Co.

18 (a) Funeral director Wm. J. Gialkowski
(b) Address 2007 Eastern Ave.

(Date) APR 3 1947 (Date registered) Registrar Huntingtown Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2, 1947 at 7:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 25 1946 to Apr. 2, 1947, and that I last saw h. (M) alive on Apr. 2, 1947.

Immediate cause of death	Duration
Postoperative Shock	8 hrs.
Due to Constrictive Peri-Carditis	1 Year
Due to Tuberculosis, pulmonary	(?) Years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation April 2, 1947
Major findings of operation: Constrictive pericarditis
of autopsy: Confirmatory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No.
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Rocco L. Laparato M. D.
Address South Balto Gen. Hospital Date signed 4/2/47

VS 150

X

G50321 BCH 762.5 B 74686

AB-109484

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

161a

Registered No. G50321

MARGIN RESERVED FOR BINDING. The following item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3hrs-34min.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
4 City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1903 W. Lafayette ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Baby Girl Short

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 28-1947

8. AGE: Years	Months	Days	If less than one day
			3 hr. 34 min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Horace Short
13. Birthplace Va.

MOTHER
14. Maiden Name Isabelle Green
15. Birthplace Pa.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 3-31-47 (month) (day) (year)
(c) Cemetery or crematory Baltimore City Hospitals
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (Date received by registrar) APR 3 1947 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28th 19 47, at 9.40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-28- 1947, to 3-28 19 47, and that I last saw h er alive on 3-28th 19 47

Immediate cause of death	Duration
Bilateral pulmonary atelectasis	3 hrs.
Due to Congenital causes	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Bilat. pulmonary atel.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Louis Bland M. D.
Address 4940 Eastern Ave. Date signed 4-2-47

VS 150

X

G50322
AB-108997 BCH# 73333 116

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G50322

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1129 N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8- 1947

8. AGE: Years	Months	Days	If less than one day
		10	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jesse Taylor
13. Birthplace ?

MOTHER
14. Maiden Name Madeline Mauthe
15. Birthplace Michigan

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 4-1-47 (month) (day) (year)
(c) Cemetery or crematory Baltimore City Hospitals
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (a) APR 3 1947 (b) Filed by registrar Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

PM

20. DATE OF DEATH March 18 19 47, at 11.50

21. I certify that death occurred on the date above stated; that I attended deceased from 3-8- 19 47 to 3-18 19 47 and that I last saw h 1m alive on 3-18 19 47.

Immediate cause of death	Duration
Prematurity	Life
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wilson E. Hughes M. D.
Address Balto City Hosp Date signed Mar 20 '47

X

G50323 420.1 BALTIMORE CITY HEALTH DEPARTMENT G50323
CERTIFICATE OF DEATH 194a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 861 W. Fayette St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 861 W. Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Mary Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1866

8. AGE: Years: 80 | Months: 10 | Days: 9 | If less than one day: hr. min.

9. Birthplace: Georgetown, Md. (Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: George Johnson
13. Birthplace: Md.

MOTHER
14. Maiden Name: ?
15. Birthplace

16 (a) Informant: Ophelia Johnson.
(b) Address 861 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 3, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Ambrose
Location

18 (a) Funeral director: Mrs Katie R Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS APR 3 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-31-1947, at 3p M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/29 1947 to 3/31 1947, and that I last saw him alive on 3/29 1947.

Immediate cause of death	Duration
Acute Cardiac Failure	
Coronary Thrombosis	4 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]
Address 1000 Linden Ave Date signed 4/1/47 M. D.

X

G50324

BALTIMORE CITY HEALTH DEPARTMENT

584 CERTIFICATE OF DEATH 126

G50324 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 47 days
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Pasadena (If outside city or town limits, write RURAL and give town)
(d) Street No. Long Point Lake Shore (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Louise Bertier

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife William Bertier
6 (c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) June 9, 1872

8. AGE: Years 74 | Months 9 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name ? Bass
13. Birthplace Pittsburg, Pa.

MOTHER
14. Maiden Name ? ?
15. Birthplace ? ?

16 (a) Informant William Bertier (Husband)
(b) Address Long Point, Pasadena, A. A. Co., Md.

17 (a) Burial — (Burial, cremation, or removal) (b) Date thereof April 5, 1947 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location Anne Arundel Co., Md.

18 (a) Funeral director A. Howard Evans
(b) Address 1400 Charles St., Baltimore, Md.

19 APR 3 1947 (Date rec'd by local registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/2/47 19 at 3:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/14 1947 to 4/2 1947 and that I last saw h[illegible] alive on 4/2 1947.

Immediate cause of death	Duration
Cardio-Respiratory failure	
Due to Empyema of Gall Bladder	
Due to Chronic Cholecystitis Cholelithiasis	
Other Conditions Diabetes mellitus (Include pregnancy within 3 months of death)	

Date of operation 3/2/47
Major findings of operation: Drained Empyema of Gall Bladder
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry J. Wilson Jr. M. D.
Address St. Josephs Hosp. Date signed 4/3/47

X

AB-10703 G50325 BCHD 30457

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G50325

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 612 Cumberland St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Gloria Isabella Barnes Bradford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 11- 1945

8. AGE: Years	Months	Days	If less than one day
1	7	20 21	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Barnes
13. Birthplace ?

MOTHER
14. Maiden Name Maybelle Bradford
15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/4/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md
18 (a) Funeral director Geo. H. Kelly
(b) Address 1303 Presstman St.

19 (a) (Date received by registrar) (b) Registrar

APR 5 1947

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1947, at 12.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-11 1947, to 4-1 1947, and that I last saw her alive on 4-1- 1947.

Immediate cause of death	Duration
Tuberculous meningitis	1 mo.
Due to Tuberculosis of mediastinal lymph nodes.	3 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wilson E. Hughes M. D.
Address Balto City Hosp Date signed Apr 2 '47

G50326

BALTIMORE CITY HEALTH DEPARTMENT

443.1 CERTIFICATE OF DEATH 93D

G50326
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: President Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1205 Whatcoat St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Pauline Brooks

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife John (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years 55 | Months | Days | If less than one day hr. min.

9. Birthplace ?? (Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER 12. Name Walter Thomas

13. Birthplace ?

MOTHER 14. Maiden Name Hattie Bullock

15. Birthplace ?

16 (a) Informant John Brooks

(b) Address 1205 Whatcoat St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/5/47 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Md.

18 (a) Funeral director Wes. H. Nelson

(b) Address 1303 Pennsylvania Ave

19 (a) Filed 4/3/47 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2nd 1947 at 12.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 19 1947 to April 2nd 1947 and that I last saw her alive on April 1st 1947

Immediate cause of death Cerebral Accident — Duration 14 days

Due to Hypertensive Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph C. Smith M. D.

Address President Hospital Date signed 4-2-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

650327 443.1

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. 650327

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 423 Cambria St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 423 Cambria St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles A. Lawson

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-03-4723

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Hattie M. Lawson
6 (c) If alive, give age No years

7. Birth date of deceased (mo., day, yr.) Nov 20 - 1879

8. AGE: Years	Months	Days	If less than one day
67 68	4	21	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business B & O R.R. Co

FATHER
12. Name Benj. Lawson
13. Birthplace Balto Md

MOTHER
14. Maiden Name A. Stockman
15. Birthplace Balto Md

16 (a) Informant Mrs. Vernon A. Lawson
(b) Address 423 Cambria St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/4/47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location Gov. Ritchie Highway

18 (a) Funeral director Milton Schilling
(b) Address 3914 Harford Ave

19 APR 3 1947 (b) Huntington Williams, M.D. Registrar
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1st 1947 at 1.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/31 1947 to 4/1 1947 and that I last saw h[illegible] alive on 4/1 1947

Immediate cause of death	Duration
Acute Heart Failure due to	
Hypertension Cardio-vascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Rubin M. D.
Address 203 Arlington Ave Date signed

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G50328 252.0 / 63 B

Registered No. G50328

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address RAINIER & DUKELAND Sts.
(c) Hospital or institution WEST BALTIMORE
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) 73

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALT.
(c) City or town BALTIMORE.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2918 CLENOAK AVE (Carney)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA W. WICK

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	M

6 (b) Name of husband or wife FRANK WICK
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 1872

8. AGE: Years	Months	Days	If less than one day
73	9	1	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Julius Jamke
13. Birthplace Ger.

MOTHER
14. Maiden Name Johanna Schaninger
15. Birthplace Ger.

16 (a) Informant Frank Wick
(b) Address 2918 Clenoak Ave (Carney)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 5 47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St.

19 (a) APR 3 1947 by registrar Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/2/47 19 , at 5:15 PM M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/30 1947 to 4/2 1947, and that I last saw h alive on 4/2 1947.

Immediate cause of death	Duration
Congestive Failure	2 DAYS.
Due to Arteriosclerosis	?
Due to Hypertrophy Cordis	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature W. B. Humphrey M. D.
Address W. B. G. H. Date signed 4-3-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50329 D 341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

Registered No. G50329

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2729 Berry's Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2729 Berry's Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Matilda A. Wiser

3 (b) If veteran, name war

3 (c) Social Security Account No. No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John J.

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Sept 14 1890

8. AGE: Years 56 | Months 6 | Days 18 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Frederick Clasing

13. Birthplace Germany

MOTHER 14. Maiden Name Elizabeth Meeks.

15. Birthplace Germany

16 (a) Informant John J. Wiser

(b) Address 2729 Berry's Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 5 47 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Eastern Ave Rd

18 (a) Funeral director Mark W. Appold's

(b) Address 7110 Belair Rd

19 (a) ..... (Date rec'd by registrar) (b) .....

V S 150 APR 8 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1947 at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-17 1947 to 4-2 1947 and that I last saw h[illegible] alive on 4-1 1947

Immediate cause of death: Cerebral Hemorrhage — Duration 3-17-47
Due to: Left Hemiplegia — 3-17-47
Due to: Malignant Hypertension — 10 yrs
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William L. Feary M. D.
Address 3025 Belair Rd Date signed 4-2-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G50330 422.1 94a

Registered No. G50330

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3916 Belvedere Ave.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3916 Belvedere Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Muffoletto,

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Josephine Muffoletto,
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 25, 1864

8. AGE: Years	Months	Days	If less than one day
82	9	5	hr. min.

9. Birthplace Italy
(Town, county, and state)
10. Usual Occupation Retired Blacksmith,
11. Industry or business

FATHER
12. Name Anthony Muffoletto,
13. Birthplace Italy,

MOTHER
14. Maiden Name unknown,
15. Birthplace Italy,

16 (a) Informant Mr. Anthony Muffoletto,
(b) Address 3916 Belvedere Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/2/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral,
Location

18 (a) Funeral director L. Vernon Lemmon
(b) Address 4611 Park Heights Ave.,

19 (a) (Date rec'd by Local Reg.) APR 3 1947 (b) Filed by Local Reg. (Signature) Address

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 30, 1947, at 830 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 25 1945 to 3/30 1947, and that I last saw him alive on 3/30 1947.

Immediate cause of death Myocardial Infarct — Duration 2 days.
Due to
Due to
Other Conditions General Arterio-sclerosis — 7
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D. T. Magna M. D.
Address 3226 Frederick Ave. Date signed 3/31/47

X

G50331 491

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G50331

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1011 Hanover St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1011 Hanover St,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Joyce Wood,

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 9, 1934

8. AGE: Years	Months	Days	If less than one day
12	3	22	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation school child
11. Industry or business

FATHER
12. Name Harry Wood,
13. Birthplace ~~Baltimore~~ Md.

MOTHER
14. Maiden Name Anna Gray,
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Harry Wood,
(b) Address 1011 Hanover St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/5/47 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location a.a.Co. Md

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 Park Heights Ave.

19 (a) (Date rec'd by registrar) (b) Registrar Baltimore Md.

V S 150 APR 3 1947

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH April 1, 1947, at 11 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/31/47 19 , to 4/1/ 1947.
and that I last saw her alive on 4/1/ 19 47.

Immediate cause of death	Duration
Acute broncho-pneumonia	2 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature X Harry Weibel M. D.
1226 Hanover St. Date signed 4/1/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50332 4722 — BALTIMORE CITY HEALTH DEPARTMENT — CERTIFICATE OF DEATH 937 — Registered No. G50332

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 350 Whitridge Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 → 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 350 Whitridge Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CAROLINE WIESE

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife –
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 28, 1860

8. AGE: Years	Months	Days	If less than one day
86	7	3	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation – none
11. Industry or business

FATHER
12. Name Conrad Wiese
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mr. Wm. A. Lobar, nephew
(b) Address 350 Whitridge Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/4/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

APR 3 1947 — Huntington, Md. — VS

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 1 1947 to Apr 1 1947 and that I last saw h[er] alive on Apr 1 1947

Immediate cause of death: Bronchopneumonia — Duration 2 wks
Due to:
Due to:
Other Conditions Chr. Myocarditis — Duration Undefined
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nathaniel M Beck M. D.
Address 160 E. 22nd St. Date signed 4-13-47

107

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G50333 443.1 X 937

Registered No. G50333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hospt
(c) Hospital or institution: Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 341 Cecil Ave. Brooklyn, Md.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Elizabeth Hamtacher

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife George

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 6, 1882

8. AGE: Years 64. Months 6 Days 28 If less than one day hr. min.

9. Birthplace Scotland. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business at home

FATHER 12. Name James Morgan.
13. Birthplace Scotland

MOTHER 14. Maiden Name Ellen Templeton
15. Birthplace Scotland.

16 (a) Informant Mr Geo Hamtacher
(b) Address 341 Cecil Ave Brooklyn Md

17 (a) Burial Linwood (b) Date thereof 4/7/47 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Glendale Cem
Location Bloomfield P.O. J.

18 (a) Funeral director John J Gordon & Son
(b) Address 2403 Eastern Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS 10 APR 3 1947 Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 April 1947 at 5:00 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-19-1947 to 4-3-1947 and that I last saw her alive on 4-3-1947.

Immediate cause of death	Duration
Resp Failure	
Due to Cerebro-vasc. accident	
Due to Probable intracranial hemorrhage	
Other Conditions Hypertensive Arter. CVD Taurie fibrillation.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harvey

Address Univ. Hosp. Date signed 4-3-47 M. D.

X

G50334 BCH 991 E994 #66845

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G50334 1820

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1603- Elrino St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1603 Elrino St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LINDA C BARAN

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 27-1946

8. AGE: Years	Months	Days	If less than one day
	3	10	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Walter J. Baran
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Ida B. Bymion
15. Birthplace Balto., Md.

16 (a) Informant Walter J. Bymion
(b) Address 1603 Elrino St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/5/47 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem.
Location Balto., Md.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway

19 (a) APR 3 1947 (Date received by registrar) (b)

Registrar Williams, M.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3, 1947, at 5.40 a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Mechanical Suffocation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-3-47 at A M.
(b) Where did injury occur? 1603 Elrino St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Suffocation by bedclothes in

23. Signature Carl L. Boyer M.D. Medical Examiner.
Date signed 4-3-47

VS 151

X 127

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

650335 968 E892

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

178 B

Registered No. 650335

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 611 St. Paul St.
(c) Hospital or institution: ----------
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 611 St. Paul Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Graham Watson

3 (b) If veteran, name war ----------

3 (c) Social Security Account No. ----------

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret O'Sullivan

6 (c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) ----------

8. AGE: Years: 73 | Months: | Days: | If less than one day: hr. min.

9. Birthplace: Centerville, Md. (Town, county, and state)

10. Usual Occupation: Salesman

11. Industry or business: American Book Co.

FATHER
12. Name: John Watson
13. Birthplace: Centerville, Md.

MOTHER
14. Maiden Name: Mary Wilmer
15. Birthplace: Centerville, Md.

16 (a) Informant: Mrs. Graham Watson
(b) Address: 611 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/4/47 (month) (day) (year)
(c) Cemetery ####### Centerville,
Location: Centerville, Md.

18 (a) Funeral director: H. W. Mears and Son
(b) Address: 805 N. Calvert Street

19 APR 3 1947 (Date rec'd by local reg.) (b) Huntingtown, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1947 at 8 30 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Asphyxiation

Due to: Carbon monoxide poisoning.

Other Conditions: Coronary occlusion

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-1-47 at 7 P M.
(b) Where did injury occur? 611 St. Paul St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury: Inhalation of automobile exhaust fumes

23. Signature: Earl L. Royer M.D. Medical Examiner.
Date signed 4-2-47

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X

G50336 422.1 BALTIMORE CITY HEALTH DEPARTMENT 1937 G50336

CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1710 Linden avenue
(c) Hospital or institution: 14

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1710 Linden ave.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES W. TIGHE

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	Widowed

6 (b) Name of husband or wife Bessie Sweeney Tighe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 13, 1868

8. AGE: Years	Months	Days	If less than one day
79	-	19	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name John M. Tighe
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen O'Rourke
15. Birthplace Ireland

16 (a) Informant Miss Cecilia A. Tighe
(b) Address 1710 Linden avenue

17 (a) Burial (b) Date thereof 4/4, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick road

18 (a) Funeral director Chas. J. Evans Son Inc
(b) Address 118 N. Mt. Royal Ave

19 (a) Filed APR 3 1947 (Registrar's signature) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 19 47, at 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 14 1947 to Apr. 2 1947 and that I last saw h[illegible] alive on Apr. 2 1947.

Immediate cause of death Myocarditis, chronic — Duration —
Due to Osteosclerosis —
Due to
Other Conditions Senile Depression, Psychosis —
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wilkins A. Linton
Address 2824 St. Paul St. Date signed 4/3/47
Baltimore, Maryland.

G50337 002

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G50337

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 12 11 Light St
(c) Hospital or institution: So Balto Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10d
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED: Anne Arundel
(a) State Md (b) County Balto
(c) City or town Brooklyn Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. Box 71 A Glen Burnie
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella (Brannan) BRANHAM (Name used both ways)

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex F | 5. Color or race W | 6 (a) Single, (Married) widowed, or divorced.

6 (b) Name of husband or wife John Brannan

6 (c) If alive, give age (65) 66 years

7. Birth date of deceased (mo., day, yr.) May 20 (1879) 1880

8. AGE: Years 66 (67) | Months 10 | Days 12 13 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation H W

11. Industry or business

FATHER
12. Name George Campbell
13. Birthplace Virginia

MOTHER
14. Maiden Name Isabelle Belvin
15. Birthplace Virginia

16 (a) Informant Mrs. Pearl Adcock
(b) Address Route 9, Brooklyn 25, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 5, 47 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie, Md.

18 (a) Funeral director Thomas W. Singleton
(b) Address Glen Burnie, Md.

19 (a) 1883 1947 (b) Huntington Williams, M.D. Registrar
(Registered by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 - 2 1947, at 8:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4 - 1 1947 to 4 - 2 1947 and that I last saw her alive on 4 - 2 1947.

Immediate cause of death: Overwhelming Toxemia

Due to: Miliary Pulmonary Tuberculosis

Due to: Ruptured appendix. Generalized Peritonitis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: Miliary Tbc - Peritonitis

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold Gillon M. D.
Address Sou. Balto. Gen. Hosp. Date signed Apr. 3, 1947

VS 150

G50338 763

DC# 27682 107

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 107

G50338
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison and Linden
(c) Hospital or institution: Md. Gen. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1916 Alhambra Ave
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Baby Girl Hontz

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/31/47

8. AGE: Years	Months	Days	If less than one day
			7 hr. min.

9. Birthplace Balto - Md
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Burnell Hontz
13. Birthplace ?

MOTHER
14. Maiden Name Martha Wickett
15. Birthplace Pa.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School APR 3 1947

18 (a) Funeral director Commissioner of Health
(b) Address

APR 3 1947 Hartley Ford Williams, M.D.
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-31-47 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-31-47 19 , to 3-31-47 19 , and that I last saw h[illegible] alive on 3-31-47

Immediate cause of death	Duration
Asphyxia	
Due to Aspiration Pneumonia	
Due to	
Other Conditions Atelectasis	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas C Webster M. D.
Address Md. Gen. Hosp Date signed 4-2-47

G50339

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G50339 Registered No.

BH # 80647776 159

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address.....

(c) Hospital or institution: Univ. Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balt

(c) City or town Balt

(If outside city or town limits, write RURAL and give town)

(d) Street No. 117 S Broadway Eastern & Patterson

(If rural give location)

(e) Citizen of foreign country?.....(Yes or No)

If yes, name country.....

3 (a) FULL NAME Baby Girl Minnick

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fem	w	infant

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 3-31-47

8. AGE: Years	Months	Days	If less than one day
		1	..... hr. ..... min.

9. Birthplace.....
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER 12. Name John Mellvaine Minnick

13. Birthplace Wash. Co

MOTHER 14. Maiden Name Mary Britain

15. Birthplace Balt

16 (a) Informant Polly Kerns

(b) Address 117 S Broadway

17 (a)..... (b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory.....

Location University Medical School APR 3 1947

18 (a) Funeral director..... Commissioner of Health

(b) Address.....

19 (c) APR 3 1947 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-31 1947, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-31 1947 to 3-31 1947 and that I last saw her alive on 3-31 1947.

Immediate cause of death	Duration
Prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide.....

(b) Date of occurrence..... at..... M

(c) Where did injury occur?.....
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)

(e) Means of injury.....

23. Signature Wm. Bosley Jr.

Address Univ. Hosp. Date signed 4-7-47 M. D.

G50340 762.5 BALTIMORE CITY HEALTH DEPARTMENT Registered No. G50340
BC#B-74170 CERTIFICATE OF DEATH 159

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Eutaw
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1¼ days
(e) Length of stay in Baltimore (yrs., mos., or days) 1¼ days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balt. Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2802 Seamans Rt Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Chappelle

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: None
6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) 3/24/47

8. AGE: Years 0 | Months 0 | Days 1¼ | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER 12. Name ?
13. Birthplace

MOTHER 14. Maiden Name Mildred Chappelle
15. Birthplace

16 (a) Informant Mildred Chappelle
(b) Address 2802 Seamans Rt Rd

17 (a) ____ (Burial, cremation, or removal) (b) Date thereof ____ (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

APR 3 1947 (Date rec'd by Registrar)

University Medical School APR 3 1947 Commissioner of Health

(b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/23 1947, at 6:04 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/19 1947, to 3/22 1947, and that I last saw him alive on 3/23 1947.

Immediate cause of death	Duration
Bilateral atelectasis	
Due to prematurity.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address Date signed 3/23

650341 307 E810.0 BALTIMORE CITY HEALTH DEPARTMENT 650341 Registered No.

CERTIFICATE OF DEATH 170c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Essex (If outside city or town limits, write RURAL and give town)
(d) Street No. 2103 Old Eastern Ave. (If rural give location)
(e) Citizen of foreign country? Essex (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin B. Baer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 60 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation ?

11. Industry or business ?

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant ?
(b) Address ?

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/6/47 (month) (day) (year)
(c) Cemetery or crematory Slate Ridge Cem
Location Delta, Pa.

18 (a) Funeral director Chas P. Powell
(b) Address 2427 Edmondson Ave

19 (a) APR 3 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION 55

20. DATE OF DEATH April 2, 1947, at 10 A. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH (a) Lobar Pneumonia

Due to

Other Conditions (b) Subarachnoid Hemorrhage (c) Fracture 7-8-9 Rt. ribs.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/24/47 at 2:20 P. M.
(b) Where did injury occur? Eastern Blvd. and Harrison St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian Struck by Auto

23. Signature Earl L. Kaylor M.D. Medical Examiner.
Date signed 4/5/47

G50342 422.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

Registered No. G50342

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street city.
(c) Hospital or institution: Little Sisters of the Poor.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 86 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years.

3 (a) FULL NAME Annie Kaney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widowed

6 (b) Name of husband or wife Frank J. Haney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4, 1860

8. AGE: Years	Months	Days	If less than one day
86	9	6	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Seamstress
11. Industry or business

FATHER
12. Name John H. Brand
13. Birthplace Germany

MOTHER
14. Maiden Name Kathrena Dearberger
15. Birthplace Germany

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley Street city

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 5 1947 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Ryan Weedfield
(b) Address 900 E. Biddle St

19 (Date received by registrar) APR 3 1947 Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2- 1947, at 6-40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Mch 10- 1947, to April 2- 1947, and that I last saw her alive on April 1- 1947.

Immediate cause of death	Duration
Edema Lungs-	2 days
Due to Chronic myocarditis	5 yrs
Due to	
Other Conditions Arterio - Sclerosis	10 yrs

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Gill Hall
Address 1631 E North Av Date signed 4/3/47 M. D.

X

650343 443.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 650343

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd St. & Guilford Ave.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (~~years, months,~~ or days) 54
(e) Length of stay in Baltimore (~~years, months, or days~~) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Owings Mills (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Burton Belt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Edward Belt
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) March 23, 1893

8. AGE: Years 53 | Months - | Days 10 | If less than one day ..... hr. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Clifford P. Burton
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Annie Beck
15. Birthplace: Maryland

16 (a) Informant: Hospital records
(b) Address: 33rd St. & Guilford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 5, 1947 (month) (day) (year)
(c) Cemetery or crematory: Green Mount
Location: Baltimore

18 (a) Funeral director: Rita Wiedefeld
(b) Address: 900 East Biddle St

19 APR 3 1947 (Date rec'd by local registrar) (b) Huntington Hillsborough, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2, 1947, at 4:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 27, 1947, to April 2, 1947, and that I last saw h.e. alive on April 2, 1947.

	Duration
Immediate cause of death: Cerebral hemorrhage	2 hrs.
Due to: Hypertensive cardiovascular disease	?
Due to: Chronic pyelonephritis	?
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: J. Erskine Hagood M. D.
Address: Union Memorial Hosp. Date signed 4-7-47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50344 420.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registration No. G50344

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 900 Cathedral St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 900 Cathedral St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Michael Mc Donnell

3 (b) If veteran, name war: W. W. *2
3 (c) Social Security Account No. 052-18-8271

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 13th 1903

8. AGE: Years	Months	Days	If less than one day
43	6	20	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Florist
11. Industry or business Own Business

FATHER
12. Name John J. Mc Donnell
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Alice Snyder
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Alice Jones
(b) Address 2519 Calverton Heights Ave.

17 (a) Burial (b) Date thereof 4/7/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md.

18 (a) Funeral director Wilhorn & Son
(b) Address 2440 Pa. Ave

APR 1 1947
(Date rec'd by registrar)

(b) Hunting Williams M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3, 1947 at 8:40 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.

Date signed Apr. 7, 1947

X

G50345

341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G50345
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor & Dukeland
(c) Hospital or institution: West Balto Den't Hosp. 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 hours
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5066 Mayfield Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oscar T. Jones. Oscar Theodore Jones

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-22-5571

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Clara Burk Jones

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) August 26, 1877

8. AGE: Years 69 | Months 7 | Days 7 6 | If less than one day ... hr. ... min.

9. Birthplace New Orleans, La.
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Fuller Brush Co.

FATHER
12. Name William T. Jones
13. Birthplace New Orelans, La.

MOTHER
14. Maiden Name Agnes Fox
15. Birthplace New Orelans, La.

16 (a) Informant Mrs. Clara Burk Jones
(b) Address 5066 Mayfield Ave.

17 (a) Entombment (Burial, cremation, or removal) (b) Date thereof April 5, 1947 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral director E. Millis Lamoreaux
(b) Address 4510 Liberty Heights Ave.

19 (a) 1947 (Date rec'd by registrar) [illegible] Registrar

APR 4

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 April 19 47 at 8:37 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2 April 1947 to 2 April 1947, and that I last saw h[illegible] alive on 2 April 1947

Immediate cause of death: Cardiac Coma.
Due to Lacerated Heart.
Due to Congestive Failure
Other Conditions: Bilateral Pneumonia
Fatty Metamorphosis of Liver
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy: above.

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lester A. Hall Jr. M. D.
Address Wm. H. Baetjer Hosp. Date signed 2 April 47

G50346 5811

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G50346 Registered No. 124a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1230 Carroll St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give name)
(d) Street No. 1230 Carroll St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William J. Hunt

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 24 1891

8. AGE: Years	Months	Days	If less than one day
55	4	8	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Post Office Baltimore

FATHER
12. Name Timothy J. Hunt
13. Birthplace Ireland

MOTHER
14. Maiden Name Ella C. Fahey
15. Birthplace Maryland

16 (a) Informant Mrs Timothy J. Hunt
(b) Address 1230 Carroll St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/5/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location W. 300 Old Fred Road

18 (a) Funeral director Elliott Cowan & Son
(b) Address 901-03 Pulaski St

1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2nd 1947, at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1947 to April 2 1947, and that I last saw h[illegible] alive on April 1 1947

Immediate cause of death	Duration
Heart Block	2 days
Cerebrosis of the Liver	6 mos.
Due to Alcoholism, Chronic	10 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Edward P. Ulrich, Jr. M.D.
Address 122 W. Read Blvd Date signed 4/3/47

X

G50347 4201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G50347 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 3809 Granada Ave
(b) Street address
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 10
(e) Length of stay in Baltimore (yrs., mos., or days) 6 Months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3809 Granada Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANNIE TAUBER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late Henry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 65 | Months 6 | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business House Work

FATHER
12. Name Samuel Trachtenberg
13. Birthplace Russia

MOTHER
14. Maiden Name Celia ?
15. Birthplace Russia

16 (a) Informant Mrs Florence J Chester
(b) Address 3809 Granada Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 4, 1947 (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh Cemetery
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

APR 4 1947 (Date rec'd) (b) Huntington Millinery Md

MEDICAL CERTIFICATION 12.30

20. DATE OF DEATH April 3 1947 at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1 1947 to 4/3 1947, and that I last saw h[illegible] alive on 4/3 1947.

Immediate cause of death: Coronary Thrombosis — Duration: Sudden

Due to: Arteriosclerotic Cardio-Vascular ?

Due to: Disease

Other Conditions: Broncho-Pneumonia - Terminal

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph S. Bloom, M.D.
Address 126 E. Preston St. Date signed 4/3/47

VS 180

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50348 491 — BALTIMORE CITY HEALTH DEPARTMENT — 52B — Registered No. G-0348

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [redacted]
(c) Hospital or institution: University Hospital 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 55

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3400 Woodline Ave-7
(e) Citizen of foreign country? — (Yes or No)
If yes, name country — No —

3 (a) **FULL NAME** Philip Naas (Philip Francis Naas)

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 212-07-9748

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Margaret Naas
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Dec. 30 1890

8. AGE: Years 56 | Months 3 | Days 3 | If less than one day: ____ hr. ____ min.

9. Birthplace Baltimore- md. (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Pitt & Co.

FATHER
12. Name Philip Naas
13. Birthplace Balto.- md.

MOTHER
14. Maiden Name Ottellee Patzer
15. Birthplace Germany

16 (a) Informant Mr. Philip F Naas, Jr. - (Son)
(b) Address 2111 Garrison Ave - City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4- 5- 47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Balto.- md.

18 (a) Funeral director Stewart & Mowen Company
(b) Address 108-W- North Ave- Balto.-1-Md

19 (a) ____ (Date rec'd by registrar) (b) ____ Registrar

APR 4 1947 Huntington Williams, M.D.
VS 4-150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/2/1947, at 7 35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/26/1946 to 4/2/1947, and that I last saw h[illegible] alive on 4/1/47 1947.

Immediate cause of death	Duration
Cardio Resp. Failure	
Due to Debilatation	
Due to Carcinoma of Bladder.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [redacted] Dr. Leo K. Wilson
Address [redacted] Hosp. Date signed 4/2/47 M. D.

X

G50349 B41

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

✓ G50349 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 502 Roberts
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 502 Roberts st. (If rural give location)
(e) Citizen of foreign country? Not (Yes or No) If yes, name country

3 (a) FULL NAME Vangie Braxton.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	WIDOWED

6 (b) Name of husband or wife CHARLES
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov 18, 1887

8. AGE: Years	Months	Days	If less than one day
59	4	17/6	hr. min.

9. Birthplace King & Queen County Virginia (Town, county, and state)
10. Usual Occupation Housework.
11. Industry or business

FATHER 12. Name JOHN VESSELS
13. Birthplace Va.

MOTHER 14. Maiden Name MARY CHATMAN
15. Birthplace Va.

16 (a) Informant MRS HELEN T AYERS
(b) Address CENTERVILLE Md

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4-7-47 (month) (day) (year)
(c) Cemetery or crematory MT. AUBURN CEM
Location BALTIMORE Md.

18 (a) Funeral director William D Jackson
(b) Address 916 Pennsylvania ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D

APR 4 1941

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4, 1947, at 2:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 31 1947, to Apr 4 1947, and that I last saw h[illegible] alive on Mar 31, 1947.

	Duration
Immediate cause of death Cerebral hemorrhage	4 days
Due to Hypertension	8 yrs
Due to Arteriosclerosis	8 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David H. Andrew
Address 5410 Willowmere Way Date signed 4/4/47 (M D)

X

G50350 156 BALTIMORE CITY HEALTH DEPARTMENT ✓ G50350
Registered No.

CERTIFICATE OF DEATH 469

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2730 Mosher St.
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2730 Mosher St. 16
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAVILLA VIRGINIA ROYER

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1860

8. AGE: Years	Months	Days	If less than one day
86	8	17	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Christian Royer
13. Birthplace Md.

MOTHER
14. Maiden Name Saville Young
15. Birthplace Md.

16 (a) Informant Miss Ellen Royer
(b) Address 2730 Mosher St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/5/47 (month) (day) (year)
(c) Cemetery or crematory Meadow Branch
Location Westminster, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 1947 (b) Registered by registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1, 1947, at 3.30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1947 to Apr 1 1947 and that I last saw him alive on Mar 28 1947.

Immediate cause of death: Carcinoma of Pancreas — Duration 3 mo

Due to: General Abdominal

Due to: Carcinoma ✓

Other Conditions ✓

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: ✓
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ (Specify type of place) While at work?
(e) Means of injury ✓

23. Signature Edna A. Graham Lic. M.D.
Address 2 W. Eagle Grove Date signed 4/7/47

X

G50351 450

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 97

✓ G50351 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 701 Cathedral Street
(c) Hospital or institution: 11

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 701 Cathedral St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JULIA T. BIBB

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Charles W. Bibb

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 13, 1854

8. AGE: Years 92 | Months 6 | Days 21 | If less than one day hr. min.

9. Birthplace Montgomery City, Mo.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Dr. Benjamin Sharp
13. Birthplace Missouri

MOTHER
14. Maiden Name Mary Harrison McGhee
15. Birthplace Shelbyville, Ky.

16 (a) Informant Mr. Frank Bibb
(b) Address 701 Cathedral St.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 4/5/47 (month) (day) (year)
(c) Cemetery or crematory Greenmount Crematory
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 APR 4 1947 (b) [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2, 1947 at 6:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 15 1947 to Apr. 2 1947 and that I last saw her alive on Apr. 2 1947

Immediate cause of death	Duration
Hypostatic pneumonia	1 week
Due to	
Due to	
Other Conditions Arteriosclerosis	?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eduard Novak M. D.
Address 101 W. Read St Date signed 4-4-47

X

G50352 442.1

BALTIMORE CITY HEALTH DEPARTMENT ✓ G50352
Registered No.

CERTIFICATE OF DEATH 13 a

Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 226 S Highland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 226 S Highland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ingeborg (Engeborg) Andersen
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Alexander Andersen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 4th 1871

8. AGE: Years 76 | Months 11 | Days 29 | If less than one day ..... hr. ..... min.

9. Birthplace Norway
(Town, county, and state)

10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Thorbjörn Andersen
13. Birthplace Norway

MOTHER
14. Maiden Name Annie Danbar
15. Birthplace Norway

16 (a) Informant Madaline Smith
(b) Address 74 Yorke Way

17 (a) Burial (b) Date thereof Apr 7-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Catty

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) (Signature) Thurlington Williams, M.D.
(Date received by registrar) Registrar

APR 4 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1947 at 12 49 PM

21. I certify that death occurred on the date above stated, that I attended deceased from March 25 1947 to April 3 1947, that I last saw her alive on April 2 1947

	Duration
Immediate cause of death: Cerebral Hemorrhage (Left Side) (Last Stage)	3/25/47
Cardio-regular-renal disease	
Due to arterial Hypertension & arteriosclerosis	
Due to	
Other Conditions Obesity	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis F. Krumrein M. D.
Address 722 N. Howard Ave Date signed 4/4/47

X

G50353 151 BALTIMORE CITY HEALTH DEPARTMENT ✓ G50353
Registered No.

CERTIFICATE OF DEATH 46B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5500 Gorsuch Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5500 Gorsuch Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Lena Schweizer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Henry Schweizer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 15 1865

8. AGE: Years 81 | Months 11 | Days 19 | If less than one day hr. min.

9. Birthplace Washington D C
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name John Strott
13. Birthplace Germany

MOTHER 14. Maiden Name Dont Know
15. Birthplace Germany

16 (a) Informant Mrs Florine Wilhelm
(b) Address 5500 Gorsuch Ave

17 (a) Burial (b) Date thereof Apr 7
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Rural

18 (a) Funeral director Ulrich Funeral Home
(b) Address 200 E Orleans St

19 (a) (b)
(Date received by registrar) Registrar

APR 4 1947 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1947, at 6 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 15 1947, to April 3 1947, and that I last saw h. alive on April 2 1947.

Immediate cause of death	Duration
(a) cardiac arrest, general sarcoma metastasis, hypostatic pneumonia	10 days
Due to (b) carcinoma of stomach.	3 yrs
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. C. Ostlind M.D.
Address 447 N. Kenwood Ave Date signed 4/3/47

X

G50354 170

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 50

G50354 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2810 E Baltimore St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2810 E Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Ingram

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 14 1875

8. AGE: Years 72 | Months | Days 18 | If less than one day ... hr. ... min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business At home

FATHER
12. Name Francis Compton
13. Birthplace Va

MOTHER
14. Maiden Name Frances Meadows
15. Birthplace Va

16 (a) Informant Mrs Katherine Blackwell
(b) Address Silver Spring Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 5th (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) 1941 (Date rec'd by registrar) (b) Washington Williamsport, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1947, at 8:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 10th 1946, to 4/2 1947 and that I last saw h alive on 4/2 1947.

Immediate cause of death	Duration
Hemorrhage	2
Due to Carcinoma (Melanosis)	2 yrs
Due to anemia (Left)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H J Slanker M. D.
Address 100 N Milton Date signed 4/4/47

VS 190

X

G50355 447.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G50355
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 306 N. Mount St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) 30yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 306 N. Mount St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mittie Boone.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Robert Boone
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) 4-2-87

8. AGE: Years 60 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation Housekeeper
11. Industry or business

FATHER 12. Name Bob Williams
13. Birthplace Unknown

MOTHER 14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Robert Boone
(b) Address 306 N. Mount St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/6/47 (month) (day) (year)
(c) Cemetery or crematory Boone Town Cem
Location Weldon. N. C.

18 (a) Funeral director Metropolitan Funeral Home Inc
(b) Address 947. N. Mount St.

19 (a) 1947 (Date rec'd by registrar) (b) [illegible] Williams, Registrar

APR 4

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-2- 1947, at 10 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-28-1947 to 4-2- 1947.
and that I last saw her alive on 4-2- 1947

Immediate cause of death: Cerebral Hemorrhage — Duration 5 Days
Due to: Hypertensive Heart — 6 mos
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Page M. D.
Address 1816 N. Mount St (?) Date signed 4-2-47.

VS 150

G50356 341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8-30

Registered No. G50356

Every item of information should be carefully supplied. The... write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Ev... correct age is especially important. Physicians: please writ...

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2727 Eastern Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2727 Eastern Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isabella Marie Donnally

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/25/74

8. AGE: Years 73 | Months 2 | Days 7 | If less than one day ..... hr. ..... min.

9. Birthplace Balto - (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business At Home

FATHER
12. Name James A Donnelly
13. Birthplace Balto -

MOTHER
14. Maiden Name Anna R. Jacobs
15. Birthplace Balto

16 (a) Informant Edward E. Stevens
(b) Address 2727 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/5/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Frederick Rd

18 (a) Funeral director Lilly & Sons
(b) Address 403 S. Wolfe St.

19 (a) ..... (b) ..... Registrar

Registered by registrar Arthur Williams, MD

APR 5 1947 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1947, at 3 30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 28 1947 to April 2 1947, and that I last saw her alive on April 2 1947

Immediate cause of death: (a) Bronchial pneumonia — Duration: 3 days

Due to:

Due to:

Other Conditions: Cerebral Hemorrhage

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edgar J. Sandmann MD

Address 2128 W. Fayette St. Date signed 4/3/47

X

G50357 4201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G50357 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4115 Forest Park Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4115 Forest Park Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isadore Hankin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER 12. Name Isaac

13. Birthplace Russia

MOTHER 14. Maiden Name Libby

15. Birthplace Russia

16 (a) Informant M. Hankin

(b) Address 4115 Forest Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-4-47 (month) (day) (year)

(c) Cemetery or crematory Beth Tfiloh

Location Windsor Mill Road

18 (a) Funeral director Jack Lewis Inc

(b) Address 1439 E Baltimore St

19 (a) (Signature) by registrar Huntington Williams, M.D. Registrar

APR 4 1947

APR 5 150 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/4 1947, at 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-10 1947 to 4-4 1947, and that I last saw h[illegible] alive on 4-3 1947.

Immediate cause of death: CORONARY THROMBOSIS — Duration: 15 min

Due to: BERGER'S DISEASE — 2 yrs

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Norma R Kleeman

Address 3803 Edgecombe Ave Date signed 4/5/47 (M. D.)

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT ✓ G50358 Registered No.

G50358 592 CERTIFICATE OF DEATH 13 1a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution: Elmhurst Nursing Home 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1708 Eutaw Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** LAURA V. BAKER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Wesley Baker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21, 1863

8. AGE: Years	Months	Days	If less than one day
83	11	12	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation -
11. Industry or business -

FATHER 12. Name - Stout
13. Birthplace Unknown

MOTHER 14. Maiden Name -
15. Birthplace Unknown

16 (a) Informant Mr. Wm. W. Baker
(b) Address 3409 Grantley Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/5/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date received by Registrar APR 5 1947 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3, 1947, at 9:00 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 31 1945 to Apr. 2 - 1947 and that I last saw her alive on Apr. 2 - 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to adv. arteriosclerosis	
Due to	
Other Conditions Chr. Nephritis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Louis Jarosh M. D.
Address 1700 Eutaw Pl. Date signed 4-4-47

83a

G50359 183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

G50359 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2900 Miles Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2900 Miles Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HILDA VIRGINIA COLEMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Divorced

6 (b) Name of husband or wife Frank Greenwood
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5, 1888

8. AGE: Years	Months	Days	If less than one day
58	10	28	hr. min.

9. Birthplace Chesterstown, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Stonewall Jackson Coleman
13. Birthplace Md.

MOTHER
14. Maiden Name Alice Virginia Downey
15. Birthplace Rock Hall, Md.

16 (a) Informant Mr. Ellsworth C. Greenwood, son
(b) Address 7009 Alden Rd.

17 (a) Burial (b) Date thereof 4/5/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Chester Cem.
Location Chesterstown, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

APR 4 1947 (b)
(Date rec'd by registrar) Registrar

APR 5 VS 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3, 1947, at 9:31 M

21. I certify that death occurred on the date above stated; that I attended deceased from [illegible] 1945, to April 1947 and that I last saw h[illegible] alive on April 2 1947.

Immediate cause of death	Duration
Suffocation due to Pneumonia	
Due to Cancer of Uterus and Adnexa	about 2 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation December 1945
Major findings of operation: Cancer of uterus and adnexa
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Thomas C. Mayo M. D.
Address 716 Cathedral St. Date signed April 7, 1947

Huntington Williams, Registrar

X

G50360 434.3

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G50360
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3234 Clifton Ave.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3234 Clifton Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Estelle E. Bentzel

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife ----
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 11, 1888

8. AGE: Years	Months	Days	If less than one day
58	7	22	hr. min.

9. Birthplace Newport, R. I.
(Town, county, and state)
10. Usual Occupation Typist
11. Industry or business U.S. Fidelity & Guaranty Co.

FATHER
12. Name Charles Bentzel
13. Birthplace Newport, Pa.

MOTHER
14. Maiden Name Mary T. O'Brien
15. Birthplace Ireland

16 (a) Informant Mrs. Helen M. Murphy
(b) Address 3234 Clifton Ave.,

17 (a) Burial (b) Date thereof 4-5-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director J. Howard Storey
(b) Address 3207 W. North Ave.,

19 (a) (Date rec'd by registrar) (b) Registrar

APR 5 1947 Huntington Williams, M.D.

MEDICAL CERTIFICATION 11.15

20. DATE OF DEATH April 2, 1947, at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1946 to April 2 1947.
and that I last saw her alive on Jan 8 1947.

Immediate cause of death Chronic Myocarditis. — Duration
Due to
Due to
Other Conditions Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Alvin H. Lemmon
Address 4209 Island Ave Date signed 4/7/47

X

G50361 592

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G50361

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Meredithsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Box 58 B - Rt #1
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Conrad Mayer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-23-26

8. AGE: Years	Months	Days	If less than one day
26	10	10	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Farm Labr.
11. Industry or business

FATHER
12. Name Charles Mayer
13. Birthplace Austria

MOTHER
14. Maiden Name Josephine Wegmann
15. Birthplace Austria

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof April 4th 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Lacrosse, Va

18 (a) Funeral director Lee G. Leake
(b) Address 1701-03 N. Patterson Park ave
(c) Baltimore Maryland

APR 5 1947 (Date received) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1947 at 10 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 2 1947 to April 3 1947 and that I last saw him alive on April 3 1947.

Immediate cause of death: UREMIA
WITH SEVERE PERICARDITIS
Due to CHRONIC GLOMERULONEPHRITIS
WITH HYPERTENSION
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: WEEKS 3 DAYS

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. M. Williams M. D.
Address Johns Hopkins Hospital Date signed 4-3-47

G50362 151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 462

Registered No. G50362

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd. & Calvert ST.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 20

2. USUAL RESIDENCE OF DECEASED:
(a) State Penn. (b) County
(c) City or town Zullinger. (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Omer Harlan Scott.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married.

6 (b) Name of husband or wife Nancy Susan Scott.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 11, 1886

8. AGE: Years	Months	Days	If less than one day
61	0	24	hr. min.

9. Birthplace Zullinger Penn. (Town, county, and state)
10. Usual Occupation Farmer.
11. Industry or business

FATHER 12. Name Harvey Scott.
13. Birthplace Pennsylvania.
MOTHER 14. Maiden Name ~~Eby~~ Effie.
15. Birthplace Pennsylvania.

16 (a) Informant Mrs. Nancy Scott
(b) Address Waynesboro Pa., #4

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 7, 1947 (month) (day) (year)
(c) Cemetery or crematory Green Hill
Location Waynesboro, Pa.

18 (a) Funeral director Walter Y. Goore
(b) Address Waynesboro Pa.,

APR 5 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1947, at 2.27 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 15 1947, to Ap. 4 1947, and that I last saw him alive on Ap. 4 1947.

Immediate cause of death	Duration
Carcinoma of stomach	
Due to [Terminal Bronchopneumonia	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Carcinoma of Stomach

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Geo. H. Zeltzinger M. D.
Address U.M.H. Date signed 4/4/47

33rd Calvert St. X

G50363 | 54

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. G50363

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 n. Carolina Ave.
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5126 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine V. Lavezza

3 (b) If veteran, name war	3 (c) Social Security Account No. 213-09-3807

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 25th 1904

8. AGE: Years	Months	Days	If less than one day
42	5	19	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Matron
11. Industry or business Beth. Steel Co

FATHER — 12. Name	John L. Lavezza
FATHER — 13. Birthplace	Balto Md.
MOTHER — 14. Maiden Name	Theresa Bacig alupo
MOTHER — 15. Birthplace	Balto. Md.

16 (a) Informant Mrs. Joseph Reis
(b) Address 5126 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/7/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1257 St. Paul St.

APR 5 1947 (Date received) (Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April, 1947, at 3:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/25/47 19 to 4/4 1947 and that I last saw h. alive on 4/3 1947.

Immediate cause of death	Duration
Toxemia	10 mos
Due to Papillary cystadena-carcinoma & Abdominal Spread	Months
Other Conditions Secondary Spread to Recto Sigmoid	Months

(Include pregnancy within 3 months of death)
Date of operation 3/26/47
Major findings of operation: Bilateral cyst-adenocarcinoma of ovary Ca of abdomen, spread
Findings of autopsy: Not obtained.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James L. Shortle M. D.
Address St. Josephs Hospital Date signed 4/4/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50364 422.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G50364

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 640 S. Monroe st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 640 S. Monroe st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie B. Lewis

3 (b) If veteran, name war: W
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: George W. Lewis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 10th 1874

8. AGE: Years 73 | Months 2 | Days 23 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Edward Ridgely
13. Birthplace Howard Co. Md.

MOTHER
14. Maiden Name Susan Sullivan
15. Birthplace Howard Co. Md.

16 (a) Informant Mary E. Williams Daughter
(b) Address 640 S. Monroe st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/5/47 (month) (day) (year)
(c) Cemetery or crematory Maryland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

19 APR 5 1947 (Date) rec'd by registrar (Huntington Williams M.D.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3rd 1947, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 27 1947, to April 3 1947, and that I last saw h-er alive on March 30 1947.

Immediate cause of death: Arteriosclerosis
Cardiovascular Disease — Duration 6 mos.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert M. Katz M. D.
Address 2020 William Ave Date signed April 4 1947

VS 150

G50365 420.1 BALTIMORE CITY HEALTH DEPARTMENT X V Registered No. G50365

CERTIFICATE OF DEATH 94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure to correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd st.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt.
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 403 Hopkins Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ~~Mrs. Joseph~~ H. Woolford (Susan)

3 (b) If veteran, name war W
3 (c) Social Security Account No. none

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Joseph N. Woolford.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 25th 1879

8. AGE: Years 67 | Months 4 | Days 9 | If less than one day hr. min.

9. Birthplace No. Ca Carolina. (Town, county, and state)
10. Usual Occupation House wife.
11. Industry or business

FATHER
12. Name William I. Roberts
13. Birthplace No. Ca Carolina.

MOTHER
14. Maiden Name Susan Langdon
15. Birthplace No. Ca Carolina.

16 (a) Informant Wm J. Woolford
(b) Address 403 Hopkins Rd

17 (a) Burial (b) Date thereof 4/7/47 (month) (day) (year)
(Burial, ~~cremation, or removal~~)
(c) Cemetery or ~~crematory~~ Maryland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

19 (a) APR 5 1947 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1947, at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 31 1947, to April 4 1947, and that I last saw her alive on April 4 1947.

Immediate cause of death	Duration
Cardiac Failure.	
Due to Coronary Occlusion.	10 da.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 0
Major findings of operation: 0
of autopsy: 0

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Crawford N. Kellpatrick Jr. M.D.
Address Union Memorial Hosp. Date signed 4-4-47

VS 150

C50366 433.2 937 C50366

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 625 N. Pulaski St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 24 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 625 N. Pulaski
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Rulli

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	216-01-9838

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	Married

6 (b) Name of ~~XXXXX~~ wife Catherine Irene Rulli
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31st (1896) 1894

8. AGE: Years	Months	Days	If less than one day
(50) 52	10	3	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Bricklayer
11. Industry or business Gardner National Home

FATHER
12. Name Nicola Rulli
13. Birthplace Italy

MOTHER
14. Maiden Name Celeste?
15. Birthplace Italy

16 (a) Informant Catherine I. Rulli (Wife)
(b) Address 625 N. Pu;aski St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 5th/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Welbaroel
(b) Address 52 N. Morley St.

19 APR 5 1947 (Date rec'd by registrar) Huntingtown Williams MD

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1947 at 2:45 P.M.

21. I certify that death occurred on the date above stated that I attended deceased from [illegible] 1946 to April 3 1947 and that I last saw [illegible] alive on April 1 1947

Immediate cause of death

(a) Cerebral Embolism Duration

Due to (b) Chronic Myocarditis 2yrs

Due to (c) Chronic Bronchitis 2yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, ~~or homicide~~
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur ~~about home, on farm, industrial~~ place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R L Keyser M.D.
Address Westminster Md

VS 150

G50367 190

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X ✓ 52a

Registered No. G50367

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 92 days
(e) Length of stay in Baltimore (yrs., mos., or days) 99 days

2. USUAL RESIDENCE OF DECEASED:
(a) State NY (b) County
(c) City or town New York
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6 South St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carson, Matthew

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct. 22, 1882
8. AGE: Years 64 Months 5 Days 7 If less than one day hr. min.
9. Birthplace Glasgow, Scotland (Town, county, and state)
10. Usual Occupation Fireman
11. Industry or business Seafarer

FATHER
12. Name Wm. John Carson
13. Birthplace Scotland

MOTHER
14. Maiden Name Margaret Mc Crate
15. Birthplace Scotland

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-5-1947 (month) (day) (year)
(c) Cemetery or crematory Grays Presbyterian
Location York Rd.

18 (a) Funeral director Earl B Mohelton Jr
(b) Address 403 E 25th St.

19 (a) APR 5 1947 by registrar (b) Huntington Williamsport

VS 150

APR 5 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 29 1947, at 1 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 27 1946 to Mar. 29 1947, and that I last saw him alive on Mar. 29 1947.

Immediate cause of death Carcinoma of Right kidney with Generalized Metastasis — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank B Snell
Address U.S. Marine Hospital Date signed 4-3-47 (M. D.)

X

G50368 152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

Registered No. G50368

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 67 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3306 East Lombard
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Alice Mauck

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female

5. Color or race white

6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife deceased

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11, 1879

8. AGE: Years 67 Months 7 Days 23 If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation home

11. Industry or business

FATHER 12. Name Wallace Jannett

13. Birthplace N.C.

MOTHER 14. Maiden Name Alice Ann Fields

15. Birthplace Baltimore

16 (a) Informant Hosp. Record.

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 8 1947 (month) (day) (year)

(c) Cemetery or crematory Baltimore City Cem.

Location

18 (a) Funeral director Ulrich Funeral Home

(b) Address 2108 Orleans St

19 APR 5 1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-4-47 19 , at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-15 1947 to 4-4 1947 and that I last saw h[illegible] alive on 4-4 — 1947.

Immediate cause of death resp. failure

Due to Cont. vomiting for intestinal obstruction

Due to carcinoma of large bowel

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: obstructing carcinoma large bowel

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James J. Starlock, M.D.
Address [illegible] Date signed 4-5-47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

650369 Birth Certificate No. 74866 766.0

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 650369 161a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 25 Dunkirk Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Kuche Jr.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/2/07

8. AGE: Years | Months | Days 2 | If less than one day hr. min.

9. Birthplace Balto, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Ernest Kuche
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Anna Amelia Beber
15. Birthplace Baltimore, Md.

16 (a) Informant Anna A. Kuche
(b) Address 25 Dunkirk Rd. Md.

17 (a) Burial (b) Date thereof April 5th
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Rural

18 (a) Funeral director Ulrich Funeral Home
(b) APR 5 1907 Address of

19 (a) (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/4/07 19 , at 9 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 4/3/07 19 , to 4/4/07 , and that I last saw h alive on 4/4/07

Immediate cause of death
Central Atelectasis
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph D. Watkins M.D.
Address Church Home & Hosp. Date signed 4/4/07

G50370 416

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

Registered No. G50370

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1216 W. FAYETTE ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1216 W. FAYETTE ST
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) **FULL NAME** ANNABELLE HELWIG — (ANNA RIMER BURNS)

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-16-0940

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOW

6 (b) Name of husband or wife CHARLES C. HELWIG
6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) 4-12-05

8. AGE: Years	Months	Days	If less than one day
41	11	27	____ hr. ____ min.

9. Birthplace BLYTHEWOOD - S. C.
(Town, county, and state)
10. Usual Occupation TOOLMAKER
11. Industry or business BALTIMORE TOOL WKS

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant JOSEPH BURNS
(b) Address 1615 POPLAND ST. BALTO.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4/7/47 (month) (day) (year)
(c) Cemetery or crematory BALTIMORE NATIONAL
Location FREDERICK AVENUE

18 (a) Funeral director THOS J. KENNY - INC
(b) Address 1600 HOLLINS ST

19 (a) Filed by me APR 5 1947 (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1947, at 12 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1947 to April 3 1947 and that I last saw h[illegible] alive on April 2, 1947.

Immediate cause of death Heart Failure due to Rheumatic Heart Disease — Duration Indeterminate

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature Alfred Cole M.D.
Address 1934 Wilkens Ave Date signed 4-7-47

X

50371

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G50371 443.1 937 ✓ Registered No. G50371

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 922 S Kenwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 922 S. Kenwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katarzyna Macek

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife Andrew

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov - 1866

8. AGE: 80 years | Months 5 | Days | If less than one day ____ hr. ____ min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation housework

11. Industry or business

FATHER
12. Name Wm. Kowalewska
13. Birthplace germany

MOTHER
14. Maiden Name unknown
15. Birthplace germany

16 (a) Informant Mrs. Veronica Palewska
(b) Address 922 S. Kenwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 6/47 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location German Hill Road

18 (a) Funeral director Frankowski Inc
(b) Address 1000 S. Kenwood Ave

19 (a) APR 5 1947 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1947 at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1947 to April 3 1947 and that I last saw h alive on Apr 2 1947.

Immediate cause of death	Duration
Hypertension Arteriosclerosis C-V. Disease	4-1-47
Cerebral Hemorrhage	
Due to	
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eastchurch M.D.
Address 22 E Eager Ave Date signed 4-4-47

VS 190

X

G50372 50372 002

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH · 13B

Registered No. G50372

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4405 Prudence St
(c) Hospital or institution.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4405 Prudence St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANTHONY CYNIETA

3 (b) If veteran, name war	3 (c) Social Security Account No. 215-07-7820

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Stella
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) May 19 1890

8. AGE: Years	Months	Days	If less than one day
56	10	15	hr. min.

9. Birthplace Austria
(Town, county, and state)
10. Usual Occupation Electric Motor Operator
11. Industry or business Davison Chemical Co.

FATHER
12. Name John Cynieta
13. Birthplace Austria

MOTHER
14. Maiden Name Fronie Procek
15. Birthplace Austria

16 (a) Informant Stella Cynieta
(b) Address 4405 Prudence St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-7-47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A. A. Co.

18 (a) Funeral director Wm. L. Fialkowski
(b) Address 2007 Eastern Ave

19 (a) APR 5 1947 (Date received by registrar) Huntingtown, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1947, at 6 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1947, to April 4 1947, and that I last saw h[illegible] alive on April 3 1947.

Immediate cause of death: Pulmonary Tuberculosis — Bilateral — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Carl Lutran M.D.
Address 320 Chesapeake Ave Date signed 4/14/47

VS 150

G50373 Dr. Albert Eisenberg
2025 E. North Avenue

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

33a

Registered No. G50373

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1709 East 28th Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1709 East 28th Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Edward Borchard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Margaret
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 20, 1877

8. AGE: Years	Months	Days	If less than one day
69	6	14	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Edward Borchard
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Pfieffer
15 Birthplace Germany

16 (a) Informant Mrs. Margaret Borchard
(b) Address 1709 East 28th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/7/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 APR 5 1947 Registrar's signature for Nathaniel R. Winslow, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-3-47 19 , at 6.30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1947 to April 3 1947, and that I last saw h[illegible] alive on April 3 1947.

Immediate cause of death	Duration
Influenza and Pneumonia	3 days
Due to	
Due to	
Other Conditions Myocardial Insufficiency (Include pregnancy within 3 months of death)	1 year

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert Eisenberg M.D.
Address 2025 E. North Ave Date signed 4-4-47

V S 150

G50374 186

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

✓ Registered No. G50374

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1811 Druid Park Drive (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Thomas W. Baker

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Anna Marie
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1-20-84

8. AGE: Years	Months	Days	If less than one day
63	2	15	..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Auditor
11. Industry or business U.S. Maritime

FATHER
12. Name Medford Baker
13. Birthplace Md

MOTHER
14. Maiden Name Elizabeth W. Carthy
15. Birthplace Ireland

16 (a) Informant Record
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-7-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto.

18 (a) Funeral director Leopold J. Tuck
(b) Address 5315 Harford Rd.

19 (a) APR 5 1947 (Date filed by registrar) (b) Huntingtor Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-3-1947, at 5:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-x 1946 to 4-3 1947, and that I last saw h alive on 4-3 1947.

Immediate cause of death	Duration
CARDIAC FAILURE	
CARCINOMA of PROSTATE c EXTENSIVE METASTASES	7 mo.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation NONE.
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury .....

23. Signature Robert E. Crampton M. D.
Address Johns Hopkins Date signed 4-3-47

VS 150

G50375 F.F.Ruzicki
800 N. Patterson Pk.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

443.1 937 ✓

Registered No. G50375

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2911 Oakcrest Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2911 Oakcrest Avenue
(if rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Marie Mank

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1877

8. AGE: Years	Months	Days	If less than one day
69	9	0	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Henry Mank
13. Birthplace Germany

MOTHER
14. Maiden Name Eva Weinhard
15. Birthplace Germany

16 (a) Informant Mrs. Evelyn Dobson
(b) Address 2911 Oakcrest Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/7/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) APR 5 1947 (Date rec'd by registrar) (b) Huntington Williamson Md Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/4/47 19..., at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 19 47 to April 4 1947 and that I last saw h alive on 4/4 19 47

Immediate cause of death	Duration
Hyper-tension	
Due to Cerebral Hemorrhage	2 wks
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature F. F. Ruzicki M.D.
Address 800 N. Patterson Park Ave Date signed 4-8-47

G50376 420-1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G50376 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15-14 Division Street
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2418 Montebello Terrace (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Maria Jane O'Connell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Pezaria O'Connell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10th 1860

8. AGE: Years 87 | Months | Days 23 | If less than one day ... hr. ... min.

9. Birthplace Alabama (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Johnson
13. Birthplace Alabama

MOTHER
14. Maiden Name Eliza Williams
15. Birthplace Alabama

16 (a) Informant Mrs Helen L. Roberts
(b) Address 2418 Montebello Terrace

17 (a) ✓ (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Int Auburn
Location Balto Md

18 (a) Funeral director Mrs Leo H. Holland
(b) Address 1631 Druid Hill Ave

APR 5 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2nd 1947, at 9.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19... to 3-2-1947, and that I last saw her alive on 3-2-1947.

Immediate cause of death: Myocardial Failure — Duration

Due to: Coronary Thrombosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Clarence Taylor M.D.
Address 608 N Carey Date signed 4/3/47

X

G50377 442,1 BALTIMORE CITY HEALTH DEPARTMENT 1312 Registered No. G50377

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully studied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 633 Dover
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 633 Dover (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John T. Banks

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 19, 1873

8. AGE: Years 73 | Months 4 | Days 14 | If less than one day hr. min.

9. Birthplace Essex Co Va (City, county, and state)

10. Usual Occupation Minister

11. Industry or business

FATHER 12. Name Charles Banks
13. Birthplace Essex Co Va

MOTHER 14. Maiden Name Elizabeth Holmes
15. Birthplace Edelen Co Va

16 (a) Informant Fannie Banks
(b) Address 633 Dover St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 4-5-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location Baltimore Co.

18 (a) Funeral director Wm. George & Holland
(b) Address 1911 Eutaw Pl. Baltimore, Md.

19 APR 5 1947 (Date rec'd by registrar) (b) Huntington Matthews, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1947 at 12 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1/47 19 to 4/3/ 1947 and that I last saw h[illegible] alive on 4/1/ 1947

Immediate cause of death Myocarditis Degeneration Duration
Contributory Chronic Nephritis
Due to Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. H. Carroll M.D.
Address 1911 Eutaw Pl. Date signed 4/7/47

G50378 581.1

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 124a

Registered No. G50378

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 N
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 525 Dolphin Street (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Wade Taylor

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex Male | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Fannie B. Taylor
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Apr 5-1913

8. AGE: Years 33 3/4 | Months 11 | Days 28 | If less than one day ..... hr. ..... min.

9. Birthplace Meredithville, Va (Town, county, and state)

10. Usual Occupation Barber

11. Industry or business .....

FATHER 12. Name Claiborne Taylor
13. Birthplace Meredithville, Va

MOTHER 14. Maiden Name Carrie Watman
15. Birthplace Meredithville, Va

16 (a) Informant Mrs Fannie B. Taylor
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) V (Burial, cremation, or removal) (b) Date thereof 4-6-47 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem Pk
Location Balto Co.

18 (a) Funeral director Mrs Geo H. Holland
(b) Address 1631 Druid Hill Ave

19 (a) APR 5 1947 (Date rec'd by registrar) (b) .....

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1947 at 3:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-3 1947 to 4-3 1947, and that I last saw h... alive on 4-3 1947.

Immediate cause of death	Duration
Unknown Fatty degeneration of liver	
Due to chronic alcoholism	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury .....

23. Signature Philip J. Nagler M. D.
Address Johns Hopkins Date signed 4-8-47

VS 150

William H. Helfrich M.D. per Emil K. Rogen, M.D.

G50379 421.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

Registered No. G50379

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 18 days
(e) Length of stay in Baltimore (yrs., mos., or days): life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 2432 N. Howard Ste. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) FULL NAME: Diggs, Augustus

3 (b) If veteran, name war	3 (c) Social Security Account No.
WWI	218-01-5214

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	col	Married

6 (b) Name of husband or wife: Mary Saunders
6 (c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): March 10, 1881

8. AGE: Years	Months	Days	If less than one day
66	0	23?	hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: None
11. Industry or business:

FATHER
12. Name: Bowser Diggs
13. Birthplace: Charles Co. Md.

MOTHER
14. Maiden Name: Martha ?
15. Birthplace: Charles Co. Md.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-7-1947 (month) (day) (year)
(c) Cemetery or crematory: Balts. National
Location:

18 (a) Funeral director: Mrs Katie R. Williams
(b) Address: 322 N. Schroeder St.

19 APR 5 1947 (Date rec'd by registrar) (b) Huntingtown, Williams, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 2 1947, at 5 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 15 1947 to Apr. 2 1947, and that I last saw h im alive on Apr. 2 1947

Immediate cause of death	Duration
Aortitis chronic with dilatation and aortic valve incompetency. Cardiac	UNKNOWN
Due to hypertrophy with failure. Arterial hypertension.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:
23. Signature: Willys M. Monroe
Willys M. Monroe, SA Surgeon
Address: Date signed 4/2/47

G50380 490

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 108

Registered No. G50380

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 419 N. Fremont St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 419 N. Fremont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lula Jackson.

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	Widow

6 (b) Name of husband or wife Homer Jackson.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2d, 1900

8. AGE: Years	Months	Days	If less than one day
46	9	9	hr. min.

9. Birthplace Columbus, Ga.. (Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name Charles Belt.
13. Birthplace Ga..

MOTHER
14. Maiden Name Lula Belt.
15. Birthplace Ga.

16 (a) Informant Nettie Marshall daughter
(b) Address 706 Vine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 4 1947 (month) (day) (year)
(c) Cemetery or crematory W/t Auburn Cem.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (Date received by registrar) APR 5 1947 Thurlington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1947 at 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 24 1947, to April 1 1947, and that I last saw h[illegible] alive on March 31 1947.

Immediate cause of death	Duration
Lobar Pneumonia	7 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Bowers M. D.
Address 63 W. Lombard St. Date signed

X

G50381

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BC# B 74646 161c

Registered No. G50381

Every item of information should be carefully supplied. Be sure to write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Even correct age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1312 Hanover St.
(c) Hospital or institution: MD

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1312 Hanover Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BARBARA ANN VANPELT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-30-47

8. AGE: Years	Months	Days	If less than one day
		7 5	hr. min.

9. Birthplace Balto, Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace Ohio

16 (a) Informant Mrs Ruby Vanpelt Mother
(b) Address 1213 Hanover St

17 (a) (Burial, cremation, or removal) (b) Date thereof 4/4/47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross G.A. Co
Location Ritchie Highway

18 (a) Funeral director J.A. Frame & Son
(b) Address 1216 S. Charles St

19 (a) APR 5 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4, 1947, at 10:15 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Uremia Hypostatic

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D.
Medical Examiner.
Date signed 4-5-47

VS 191

X

G50382 422. BALTIMORE CITY HEALTH DEPARTMENT 937 G50382

CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully examined, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1027 Myrtle Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1027 Myrtle Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary C. Trent

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col.	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/1/1891

8. AGE: Years	Months	Days	If less than one day
75	10	1	hr. min.

9. Birthplace Essex Co., Va.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name William Henry Byrd
13. Birthplace Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Lilletta Trent
(b) Address 1027 Myrtle Ave.

17 (a) Burial (b) Date thereof 4/5/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1600 Brantly Ave.

19 APR 5 1947
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1947, at 11 A M

21. I certify that death occurred on the date above stated, that I attended deceased from April 1 1947 to April 2 1947.
and that I last saw alive on April 2 1947.
Immediate cause of death

	Duration
Due to Cerebral Thrombosis	1 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify public place)
(e) Means of injury

23. Signature
Address Date signed 4-4-47

VS 150

G50383 180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. G50383

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1520 E. Eager
(c) Hospital or institution: 4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1520 E. Eager
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lenora T. Ligon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Robert

6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) Nov 24, 1910

8. AGE: Years 36 | Months 4 | Days 10 | If less than one day: hr. min.

9. Birthplace Clayton, N.C.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Williams Thomas
13. Birthplace N.C.

MOTHER
14. Maiden Name Norma Holland
15. Birthplace N.C.

16 (a) Informant Thelma Caldwell
(b) Address 1520 E. Eager St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/6/47 (month) (day) (year)

(c) Cemetery or crematory
Location Durham, N.C.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Ave.

19 (Date rec'd by registrar) APR 5 1947 Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1947, at 1:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 4 1947, to Apr 4 1947, and that I last saw h[illegible] alive on Apr 3 1947.

Immediate cause of death	Duration
Carcinoma of Cervix Uteri	
Due to	
Due to /	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Edward Fisher M. D.
Address 1612 E. Monument Date signed Apr 4/47

VS 180

X

G50384 102

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 136

Registered No. G50384

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied—to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Woodlawn
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3506 Meadow Side Avenue
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME CHARLES F. Reilly

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 29, 1884

8. AGE: Years	Months	Days	If less than one day
63 (60)	1	3	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Plumber's Helper
11. Industry or business

FATHER
12. Name Patrick Reilly
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen Ortsifer
15. Birthplace Maryland

16 (a) Informant Phillip Reilly
(b) Address 3506 Meadow Side Avenue

17 (a) Burial (b) Date thereof 4-7-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto., Md.

18 (a) Funeral director Martin Fahey & Sons
(b) Address 1827 W. North Ave.

19 APR 5 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3, 1947, at 9:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lung abscesses

Due to Pulmonary tuberculosis

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature Earl Royer M.D.
Medical Examiner.
Date signed 4-4-47

G50385 422.1 BALTIMORE CITY HEALTH DEPARTMENT 93D G50385

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A.
(b) Street address 4221 Oakford Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4221 Oakford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Talbott

3 (b) If veteran, name war	3 (c) Social Security Account No. X X ? 1

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17 - 1868

8. AGE: Years	Months	Days	If less than one day
79	8	17	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Chas F. Talbott
(b) Address 2730 Winchester St

17 (a) Burial (b) Date thereof 4/4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location

18 (a) Funeral director Chas F. Towell
(b) Address 4427 Edmondson Ave

19 APR 5 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

*** MEDICAL CERTIFICATION**

20. DATE OF DEATH 4/4 1947, at 10 05 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic C-V
Disease
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. Williams M.D.
Medical Examiner.
Date signed 4/5/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50386 420.0

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G50386

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 dys
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Govans Mills
(If outside city or town limits, write RURAL and give town)
(d) Street No. Wards Chapel Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marion Morris

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: A. G. Morris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21 1869

8. AGE: Years 77 | Months 11 | Days 18 | If less than one day hr. min.

9. Birthplace Scotland
(Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER
12. Name Mr Adams
13. Birthplace Scotland

MOTHER
14. Maiden Name ?
15. Birthplace Scotland

16 (a) Informant Record
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 7/47 (month) (day) (year)
(c) Cemetery or crematory Oakland Cem Hampton Va
Location Hampton Va

18 (a) Funeral director John O. Mitchell Hosp
(b) Address 1908 Eutaw Place

19 (a) APR 5 19 (Date rec'd by registrar) Williamsport, Md

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1947, at 5:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 22 1947, to April 3 1947, and that I last saw h[illegible] alive on April 3 1947

Immediate cause of death	Duration
Multiple emboli to brain, lungs, kidneys, spleen	3 weeks
Due to Arteriosclerotic heart disease & carcinoma	?
Due to pleurisy	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy: Infarctions, multiple

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frances J Stephens M. D.
Address Johns Hopkins Hosp. Date signed 4-4-47

X

G50387 BC# B74623 772.5

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G50387 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St, Balto. Md.
(c) Hospital or institution:
South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8 Avenal Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Boy Beatty

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-20-47

8. AGE: Years	Months	Days	If less than one day
		14	13 hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edmarid Beatty
13. Birthplace Maryland

MOTHER
14. Maiden Name Catherine Dill
15. Birthplace Balto. Md.

16 (a) Informant ~~Holy Cross~~ Hospital Balto
(b) Address ~~Anne Arundel Co.~~

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-5-47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A.A. Co.

18 (a) Funeral director WIEDEFELD & SON
(b) Address GREENMOUNT & 22ND

19 [illegible] Filed by me 1947 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/2/47 19 at 2:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/20 1947 to 4/2 1947 and that I last saw him alive on 4/2 1947

Immediate cause of death Pneumonia — Duration

Due to Aspiration & Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address S. Balto Gen. Hosp. Date signed 4/3/47

VS 150

G50388

BALTIMORE CITY HEALTH DEPARTMENT

CWK-108705 019.0

CERTIFICATE OF DEATH

Registered No. G50388

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 8d
(e) Length of stay in Baltimore (yrs., mos., or days) 13 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1005 W Mulberry Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Gray Ransdell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11-1925

8. AGE: Years	Months	Days	If less than one day
21	10	22	hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Ransdell
13. Birthplace North Carolina

MOTHER
14. Maiden Name Elizabeth Williams
15. Birthplace North Carolina

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 4/6/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill Md.

18 (a) Funeral director H. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) APR 5 1947 (b) Received by registrar Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 19 47, at 1:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 25 19 47, to April 3 19 47, and that I last saw h. er alive on Apr. 3 1947

Immediate cause of death: Miliary Tuberculosis — Duration: 7 Wks.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Hunt M. D.
Address Balt. City Hosp. Date signed 4-3-47

X

G50389 491

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered G50389

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs (days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1104 Druid Park (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Catlin

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Black
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 4 1896

8. AGE: Years 51 50 | Months 3 | Days 7 | If less than one day hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Domestic work
11. Industry or business

FATHER
12. Name Rufus Catlin
13. Birthplace North Carolina

MOTHER
14. Maiden Name Lucy Knox
15. Birthplace North Carolina

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/7/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill, Md.

18 (a) Funeral director H. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) Rec'd by (Signature) Huntington Williams, M.D.
(b) Date APR 8 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1947, at 6:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-1-47 1947 to 4-3 1947 and that I last saw h[er] alive on 4-3 1947.

Immediate cause of death	Duration
Bronchopneumonia bilateral	4 days
Due to Cerebral atrophy due to pneumococcus meningitis	1 year
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert C. Austrian
Address Johns Hopkins Hosp. Date signed April 8 1947 M.D.

G50390 | 5 | BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G50390 No. 463

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 Mar to 5 Apr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Queen Anne's County
(c) City or town Church Hill
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Nobel L. Coppage

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Mary E. M. Coppage (c) If give, give age 57 years

7. Birth date of deceased (mo., day, yr.) Aug 24, 1882

8. AGE: Years 64 | Months 7 | Days 11 | If less than one day ____ hr. ____ min.

9. Birthplace Queen Anne Co (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER 12. Name Benjamin L Coppage
13. Birthplace Md

MOTHER 14. Maiden Name Milly Rolph
15. Birthplace Md

16 (a) Informant Mrs M.E.M. Coppage
(b) Address Church Hill

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 8 47 (month) (day) (year)
(c) Cemetery or crematory Church Hill
Location Church Hill Md

18 (a) Funeral director Edgar L Lane
(b) Address Church Hill Md

APR 6 1947 (a) (Date) (b) Washington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 April 1947 19 ... 10 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 18 Mar. 1947 to 5 April 1947.
And that I last saw him alive on 5 April 19 47.
Immediate cause of death Circulatory collapse.

	Duration
Due to Ca of Stomach	
Due to Pancreatic necrosis	
Other Conditions Subphrenic Abscess	

(Include pregnancy within 3 months of death)
Date of operation March 22 1947
Major findings of operation: Ca of Stomach.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William L. Beverley Jr M. D.
Address University Hospital Date signed 5 April 47.

G50391 G50391

581.0 124B

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address MONUMENT ST
(c) Hospital or institution: SINAI HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3926 FAIT AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary E. Carroll

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. WIDOW

6 (b) Name of husband or wife HARRY CARROLL

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 63 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace OHIO. (Town, county, and state)

10. Usual Occupation HOUSE WORK.

11. Industry or business AT HOME

FATHER
12. Name ? METZGER
13. Birthplace OHIO.

MOTHER
14. Maiden Name UNKNOWN
15 Birthplace OHIO.

16 (a) Informant ROBT. C. COOK (NEPHEW
(b) Address CANTON, OHIO.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4-8-47 (month) (day) (year)

(c) Cemetery or crematory EVERGREEN PARK
Location NEW PHILA. OHIO.

18 (a) Funeral director CHAS. S. ZEILER
(b) Address 3605 FAIT AVE.

19 (a) 1947 (Date rec'd by registrar) (b) Huntington-Williams M[illegible] Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4, 1947, at 9 35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 4, 1947, to April 4 1947, and that I last saw h[illegible] alive on April 4 1947

Immediate cause of death Gastro-intestinal hemorrhage — Duration

Due to ? esophageal carcinoma

Due to

Other Conditions Carcinoma of liver; chronic nephritis; generalized arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation 4-5-47

Major findings of operation:

of autopsy Carcinoma; Chronic nephritis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sidney Green M. D.

Address Sinai Hospital Date signed 4-5-47

G50392 | 5 | BALTIMORE CITY HEALTH DEPARTMENT X G50392

CERTIFICATE OF DEATH V 46 C

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 22 days
(e) Length of stay in Baltimore (yrs., mos., or days): 22 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Wis. (b) County:
(c) City or town: Wausau (If outside city or town limits, write RURAL and give town)
(d) Street No.: 920 Humboldt Ave. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country:

3 (a) FULL NAME: Christenson, Harold

3 (b) If veteran, name war	3 (c) Social Security Account No.
	219-10-2369

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife: Sophie Kerney
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar. 21, 1890

8. AGE: Years	Months	Days	If less than one day
57	0	13	hr. min.

9. Birthplace: Fruitport, Michigan (Town, county, and state)
10. Usual Occupation: Captain
11. Industry or business: Seafarer

FATHER
12. Name: Henry Christenson
13. Birthplace: Denmark

MOTHER
14. Maiden Name: Ida Harris
15. Birthplace: Michigan

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 8th 1947 (month) (day) (year)
(c) Cemetery or crematory: Arlington Nat. Cemetery
Location: Arlington Va

18 (a) Funeral director: J.C. Lee Sons Co
(b) Address: 304 4th St NE Washington D.C.

19 (a) 1947 (b) Filed by registrar: Huntington Williams, M.D.

APR 6

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 3 1947, at 9:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 12 1947, to Apr. 3 1947, and that I last saw him alive on April 3 1947.

Immediate cause of death	Duration
Respiratory and cardiac failure due to spinal anaesthesia	
Other conditions: Adenocarcinoma of stomach, postoperative Gastric retention, post-operative	4 mo over 4 wk

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation: Exploratory laparotomy incomplete
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:
23. Signature: Joel D. Nicholson M. D.
Address: U.S. Marine Hosp. Baltimore Md. Date signed: 4/5/47

X

G50393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

511069 2nd.1 55E

G50393 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Ring Wood
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Donald Royce

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. ✓

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-10-40

8. AGE: Years 7 | Months 11 | Days 24 | If less than one day hr. min.

9. Birthplace W. Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Cecil Royce
13. Birthplace W. Va.

MOTHER
14. Maiden Name Nettie Wilhelm
15. Birthplace W. Va.

16 (a) Informant Record
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) April (Burial, cremation, or removal) (b) Date thereof 5/3/47 (month) (day) (year)

(c) Cemetery or crematory Valley Point W Va
Location Valley Point W Va

18 (a) Funeral director John O Mitchell Mort.
(b) Address 1960 Eutaw Place

19 (a) Date received 1947 (b) Registrar Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1947 at 8:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-4-1947 to 4-4-1947 and that I last saw him alive on 4-4 1947

Immediate cause of death	Duration
Lymphosarcoma	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas C. McPherson M. D.
Address Date signed

Dr. Colley G50394 443.1

BALTIMORE CITY HEALTH DEPARTMENT G50394 Registered No.

CERTIFICATE OF DEATH 1937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2808 White Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2808 White Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James P. Caulfield

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Margaret Ann
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 20, 1862

8. AGE: Years	Months	Days	If less than one day
84	4	15	hr. min.

9. Birthplace New Castle, England
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Thomas Andrew Caulfield
13. Birthplace Isle of Helena

MOTHER
14. Maiden Name Sarah Agnes Ellerker
15. Birthplace England

16 (a) Informant Miss Margaret Caulfield
(b) Address 2808 White Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-7-47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (Date rec'd by Registrar) APR 8 1947 (b) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/4/47 19..., at ...M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1946 to 4/4 1947 and that I last saw him alive on 4/4 1947

Immediate cause of death	Duration
(a) Hypostatic pneumonia	
Due to (b) Cardiac thrombosis	
Due to (c) Senility	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at ...M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nelson Colley M. D.
Address 5703 Harford Rd. Date signed 4/4/47

X

G50395

BALTIMORE CITY HEALTH DEPARTMENT

422.1 CERTIFICATE OF DEATH 92 B

G50395 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mar 3726 Park Heights
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3726 Park Heights Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary C. King,

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife John E. King,

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 9, 1859

8. AGE: Years 87 | Months 5 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore City,
(Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business at home

FATHER
12. Name John H. Ball,
13. Birthplace Penna.

MOTHER
14. Maiden Name Mary C. Carr,
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. John J. Byrne,
(b) Address 3726 -Park Heights,

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 4/5/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location S. Vernon Lemmon.

18 (a) Funeral director
(b) Address 4611 Park Heights Ave

19 (a) (Date received by registrar) APR 6 1947 (b) [illegible] Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2, 1947, at 5. A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sprad 1947 to 4/2 1947, and that I last saw her alive on 4/2 1947

Immediate cause of death	Duration
Arteriosclerotic Cardio-Vascular disease.	
Due to Myocard degeneration.	5 yrs.
Due to	
Other Conditions (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. L. DeBarbieri M. D.
Address 4723 Park Heights Ave Date signed 4/3/47

G50396 G50395 422.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G50396 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street city
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo 1/2
(e) Length of stay in Baltimore (yrs., mos., or days) 78 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3012 Wylie ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mary Miles

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	widow

6 (b) Name of husband or wife George Miles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1869

8. AGE: Years	Months	Days	If less than one day
78 yr	10	20	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER 12. Name Thomas Germaise

13. Birthplace Germany

MOTHER 14. Maiden Name Mary Zeiler

15. Birthplace Germany

16 (a) Informant Little Sisters of the Poor

(b) Address 1200 Valley Stree

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof 4/7/47 (month) (day) (year)

(c) Cemetery or crematory Loudon Pk.

Location

18 (a) Funeral director L. V. Lemmon

(b) Address 4611 Pk. Hgts.

19 (a) APR 8 1947 (Date received by registrar) Huntington Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mch 20 1947, to April 4 1947, and that I last saw her alive on April 3 1947

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Chronic Myocarditis	3 yr
Due to	
Other Conditions Arteri-Sclerosis	8 yr

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Gill Hall, M. D.

Address 1631 E. North av Date signed 4/5/47

X

G50397 G50397 G50397

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

592 1316

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address or Location: Fayette & Calhoun
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 423 S. Eden St.
(If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country Italy

3 (a) **FULL NAME** Yolando Cummaro

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife Peter Cummaro

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 8, 1906

8. AGE: Years	Months	Days	If less than one day
39	11	26	hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace Italy

MOTHER 14. Maiden Name
15. Birthplace Italy

16 (a) Informant Peter Cummaro
(b) Address 423 S. Eden St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Kendall Direct
(b) Address 312 S. Highland Ave.

19 (a) (Date) 1947 (b) (Registrar) Registrar

APR 6

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1947, at 1:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-12-1947 to 4-3-1947, and that I last saw him alive on 4-3-1947.

Immediate cause of death: Uremia

Due to: Chronic Glomerulonephritis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration: 6 mos.

Duration: Terminal

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stanley B. Klyanowicz M.D.

Address Franklin Square Hosp. Date signed 4-5-47

VS 150

X

G50398 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G50398

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Carlin St.
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1816 Hope St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick W. Twele Jr

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-09-0919

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/19/14

8. AGE: Years	Months	Days	If less than one day
33	0	14	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Electrical Work
11. Industry or business Glen L. Martins

FATHER
12. Name Frederick W Twele Jr
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Mary A. McNichols
15. Birthplace Texas, Md

16 (a) Informant Frederick W. Twele Sr,
(b) Address 1144 Gorsuch Ave, Balto. Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 7-1947 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave. Balto. Md.

18 (a) Funeral director Thomas W. Pangleton
(b) Address Glen Burnie, Md.

19 Date rec'd by Local Registrar APR 7 1947 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION 12:30

20. DATE OF DEATH 4/3 1947 at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/29 1947 to 4/3 1947 and that I last saw him alive on 4/3 1947.

Immediate cause of death: Cardio-Respiratory Failure — Duration

Due to: Pulmonary Tuberculosis

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Catherine J. Owen
Address St Josephs Date signed M 4 D 3/47

VS 150

G50399 CWK-109382 162

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47c

Registered No. G50399

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 Days 47 8 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3224 Kingsley Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Peddicord

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Elizabath

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 3-1899

8. AGE: Years 47 | Months 8 | Days 0 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Asst. Foreman

11. Industry or business B. & O. R. R.

FATHER
12. Name Elmer
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Coates
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 7 47. (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Rd.

18 (a) Funeral director Harvey H. Nitzke
(b) Address 4101 E. Monumental Ave

19 (a) APR 7 1947 (Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH April 5 1947, at 11:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mch. 24 1947, to Apr. 5 1947, and that I last saw h. im alive on Apr. 3 1947.

	Duration
Immediate cause of death: Carcinomatosis	6 wks.
Due to: Bronchogenic carcinoma	1 yr.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation 12-8-46

Major findings of operation: as above

of autopsy: 0

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J. O'Neill

Address Balto. City Hosps. Date signed 4-4-47 M. D.

X

G50400 GILBERT RUDMAN 2517 W. BALTO ST

OPY V.13B

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G50400

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2225 W. FAYETTE
(c) Hospital or institution:
D
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
N
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2225 W. FAYETTE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HOWARD EDGAR CARTER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: MALE

5. Color or race: W

6 (a) Single, married, widowed, or divorced: DIVORCED

6 (b) Name of husband or wife: THELMA

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 5, 1911

8. AGE: Years 35 | Months 11 | Days 1 | If less than one day ... hr. ... min.

9. Birthplace BALTO. Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name CHARLES H. CARTER
13. Birthplace Md.

MOTHER
14. Maiden Name SARA SCHAFE
15. Birthplace VA.

16 (a) Informant SARA C. FORSYTHE
(b) Address 2225 W. FAYETTE

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof APR. 6 1947 (month) (day) (year)
(c) Cemetery or crematory BETHEL CEM.
Location ALEXANDRIA, VA.

18 (a) Funeral director WILLIAM COOK INC.
(b) Address 1217 ST. PAUL ST.

19 APR 7 1947 (b) Huntington-Williams, Mfr.
(Date rec'd by Reg.)

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 6 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from MARCH 1, 1947, to APRIL 6, 1947, and that I last saw h.im alive on MARCH 1, 1947.

Immediate cause of death: PULMONARY TUBERCULOSIS — Duration: 4 months

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gilbert E. Rudman M. D.
Address 2517 W. BALTIMORE ST. Date signed 4/6/47.

VS 150

G50401 580

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 125a

G50401 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave. & Dukeland St.
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 6500 Armstrong Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Shumski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 8, 1907

8. AGE: Years 40 | Months 1 | Days 29 2/3 | If less than one day hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Bar tender

11. Industry or business Tavern

FATHER 12. Name William Shumski
13. Birthplace Poland

MOTHER 14. Maiden Name Julia Matyka
15. Birthplace Poland

16 (a) Informant Joseph X. Lokuta
(b) Address Dupont Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-10-1947 (month) (day) (year)
(c) Cemetery or crematory Dupont Pa.
Location

18 (a) Funeral director Flynn-Fleming
(b) Address 1426 Light St.

19 (a) [illegible] by registrant Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6, 1947 at 12 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 4, 1947 to April 6 1947 and that I last saw h/he alive on Apr. 6, 1947

Immediate cause of death: Cardio-respiratory failure — Duration
Due to: Bronchopneumonia
Due to: Acute hepatic necrosis
Other Conditions: Portal cirrhosis and jaundice
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Bronchopneumonia, Hepatic necrosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leon Toby M.D.
Address West Balto. Gen. Hosp. Date signed 4/6/47 M D

VS 150

G50402 541.0

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1173

Registered No. G50402

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1403 Pennsylvania Avenue (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME CLAYBORN COZART

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 27, 1900

8. AGE: Years 46 47 | Months 5 | Days 29 | If less than one day ..... hr. ..... min.

9. Birthplace Durham, North Carolina (Town, county, and state)

10. Usual Occupation Cook.

11. Industry or business

FATHER 12. Name John Cozart Sr.
13. Birthplace North Carolina

MOTHER 14. Maiden Name Cora Lyons
15. Birthplace North Carolina

16 (a) Informant Mable Mangum
(b) Address 276 N. Exeter St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/5/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill, Md.

18 (a) Funeral director R. Adlestead
(b) Address 916 Druid Hill Ave.

19 APR 7 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26, 1947, at 7.25 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Ulcer of duodenum with massive hemorrhage into stomach

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at ..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 4-3-47

G50403 497 BALTIMORE CITY HEALTH DEPARTMENT 1090 G50403

CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt.
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1401 Sulphur Spring Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Mrs Harry Seager ✓

3 (b) If veteran, name war: No
3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Sarah Seager
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8th 1889

8. AGE: Years 57 | Months 10 | Days 27 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Own business

11. Industry or business Restaurant

FATHER 12. Name Clarence Seager
13. Birthplace Phillipsburg N. J.

MOTHER 14. Maiden Name Elizabeth Elburn
15. Birthplace Rock Hall Md.

16 (a) Informant Sarah Seager
(b) Address 5506 Selma Ave - Walk Rock

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/8/47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

APR 7 1947 (b) Huntington Williams, M.D. Registrar
(Date rec'd by Reg.) (year)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-5-1947, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-2-1947, to 4-5 1947, and that I last saw him alive on 4-5-1947.

Immediate cause of death	Duration
Respiratory & Cardiac failure	
Due to Secondary Pleural Pneumonia	
Due to Primary Atypical pneumonia precipitating factor	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles H. Packham M.D.
Address University Hosp. Date signed 4-5-47 M. D.

VS 150

X

G50404 Thos. Stevens Ford Rd 597 1310

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G50404

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2522 Harford Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2522 Harford Road (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Sarah Virginia Prem

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Frank X. Prem
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24 1866

8. AGE: Years	Months	Days	If less than one day
80	8	10	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John B. Manson
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Curtiss
15. Birthplace Maryland

16 (a) Informant Arthur B. Prem (Son)
(b) Address 2522 Harford Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/8/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) APR 7 1947 (b) Registered by registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4, 1947, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 30 1947, to April 4 1947, and that I last saw her alive on April 4 1947.

Immediate cause of death	Duration
Bronco Pneumonia	2d
Uraemic coma	3d
Due to Arterio Sclerosis	14y
Hypertension	14y
Due to Chronic Interstitial nephritis	14y
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. A. Stevens M. D.
Address 2818 Harford Rd Date signed 4-6-47

G50105 HEALTH DEPARTMENT—CITY OF BALTIMORE G50105

420.1 CERTIFICATE OF DEATH 1937

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3006 Weaver Ave. Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Augustus Kaufman

If U.S. Veteran specify WAR

(a) Residence: No. 3006 Weaver Ave St., ... Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Kaufman

6. DATE OF BIRTH (month, day, year) Nov 25th 1871

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
75	4	10	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. At Home

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Self

10. Date deceased last worked at this occupation (month and year) ...

11. Total time (years) spent in this occupation ...

12. BIRTHPLACE (city or town) (State or country) Balto. Md

FATHER

13. NAME Michael Snitzer

14. BIRTHPLACE (city or town) (State or country) Germany

MOTHER

15. MAIDEN NAME Mary E. Klausmeier

16. BIRTHPLACE (city or town) (State or country) Germany

17. INFORMANT Mrs. Elmer Williams

(Address) 3006 Weaver Ave.

18. BURIAL, ~~CREMATION, OR REMOVAL~~

Place Balto. Cemetery Date 4/8 1947

19. UNDERTAKER William Cook Inc.

(Address) 1217 St. Paul St.

20. FILED APR 7 1947 Functionary Williams, M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) April 5, 1947

22. I HEREBY CERTIFY, That I attended deceased from ... 1947 to April 5 1947

I last saw ~~him~~ alive on April 5 1947 Death is said to have occurred on the date stated above, at 4 P. m.

The principal cause of death and related causes of importance were as follows:

	Duration of disease
Arteriosclerotic Heart Dis.	10 yrs
Hypertension	10 yrs
Chronic Disease	10 yrs

Other contributory causes of importance:

Was an operation performed? ... Date of ...

For what disease or injury? ...

What test confirmed diagnosis? ... Was there an autopsy? ...

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ... 19...

Where did injury occur? ...
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? ... If so, specify ...

(Signed) Walter E. Kaufman, M. D.

(Address) 4301 Harford Rd.

X

Information should be carefully supplied. AGE should be given PRACTICALLY. PHYSICIAN must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50406 4431 BALTIMORE CITY HEALTH DEPARTMENT 1937 Registered G50406

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland Gen'l Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 HRS.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1012 N. Bond St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mamie Sauter

3 (b) If veteran, name war —

3 (c) Social Security Account No. 214-03-4007

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 8th 1880

8. AGE: Years 66 | Months 11 | Days 27 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Seamstress

11. Industry or business

FATHER
12. Name William Sauter
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Amelia (Unknown)
15. Birthplace Balto Md

16 (a) Informant Mrs Adam Geyer
(b) Address 412 Mondell Ave Ardmore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/8/47 (month) (day) (year)
(c) Cemetery or Crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director Wm Cook & Sons
(b) Address 127 St. Paul St

19 (a) APR 7 1947 (Date rec'd by registrar) Huntington Williamson, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1947, at 3:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 5 1947, to April 5 1947, and that I last saw her alive on April 5 1947.

Immediate cause of death Cerebro-Vascular Accident — Duration 2 HRS.

Due to Hypertensive Cardio-Vascular Disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work? (Specify type of place)
(e) Means of injury

23. Signature Ernest A. Cranmer M. D.
Address Maryland Gen'l Hosp. Date signed April 5 '47

G50407

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

572 √131a

Register No. G50407

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Ballona Avenue
(c) Hospital or institution:
Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3018 Virginia Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace M. Gardner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife James
6 (c) If alive, give age + years

7. Birth date of deceased (mo., day, yr.) Sept Abt 1865

8. AGE: Years	Months	Days	If less than one day
About 81	6	24	hr. min.

9. Birthplace New York
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Mary H. Wyatt
(b) Address 3019 Virginia Avenue

17 (a) removal (b) Date thereof 4/8/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Green Wood
Location New York

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) APR 7 1947 Hunter Williams, M.D.
(Registered by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5, 1947, at 6:19 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mch 14 1945 to Apr 5 1947
and that I last saw ha[illegible] alive on Apr 5 1947

Immediate cause of death Chronic Myocarditis

	Duration
Due to	
Due to	
Other Conditions Arteriosclerosis Chronic Nephritis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Richardson M.D.
Address 1170 W. 20th St Date signed Apr 5: 47

VS 150

G50108 420.1

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. G50108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 Caroline St. –
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 606 N. Eugene Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward C. ~~Jackisch~~ JACKISCH (JOCHKISCH)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	

6 (b) Name of husband or wife Minnie Smoot Jackisch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4, 1906

8. AGE: Years	Months	Days	If less than one day
40	11	28	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business Baltimore News-Post

FATHER
12. Name William Jackisch
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Theresa Wieners
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Minnie Smoot Jackisch
(b) Address 606 N. Luzerne Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/8/1947 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Holy Redeemer Cemetery
Location 4430 Belair Road, Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (Date received by registrar) APR 7 1947 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4, 1947, at 6:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 19 1947 to April 4 1947.
and that I last saw h alive on April 4 1947.

Immediate cause of death Cerebral embolism – apoplectic coma
Due to Coronary atherosclerosis heart disease with cardiac hypertrophy.
Other conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Myocardial degeneration, stenosis of aortic valve, intracranial hemorrhage, cerebral embolism

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature H. H. Sturms M. D.
Address St. Josephs Date signed 4/7/47

X

G50109

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

422.1 937

Registered No. G50109

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3908 Foster Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore,
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3908 Foster Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY VEYSTRK.,

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife latePeter Veystrk
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1, 1865

8. AGE: Years	Months	Days	If less than one day
82		3	hr. min.

9. Birthplace Austria
(Town, county, and state)
10. Usual Occupation Housewife at home
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace

16 (a) Informant Agnes Blum
(b) Address 3908 Foster Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/7/47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cemetery
Location German Hill Road

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street.

19 (Date rec'd by registrar) APR 7 1947

Huntington Williams, M.D. Registrar

VS 188

MEDICAL CERTIFICATION A.

20. DATE OF DEATH April 4th 1947, at 12:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 16 1947 to April 4 1947 and that I last saw h[er] alive on Apr 3 1947

Immediate cause of death	Duration
Arteriosclerosis & Diabetes Chronic	
Due to Congestive Heart Failure	Years 1/12
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ? at M
(c) Where did injury occur? (Town or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature C.E. Schimunek M. D.
Address 942 E. Eutaw Date signed 4-7-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50110 4243 V

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G50110

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1430 Linden Avenue
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1430 Linden Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Flaig

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6, 1863

8. AGE: Years	Months	Days	If less than one day
83	5	29	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Heena Flaig

13. Birthplace Germany

MOTHER 14. Maiden Name Marie Suberger

15. Birthplace Germany

16 (a) Informant August H. Flaig

(b) Address 1430 Linden Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/8/47 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location 4400 Belair Road

18 (a) Funeral director Lilly & Sisler Inc

(b) Address 403 S. Wolfe Street

19 APR 7 1947 (Date rec'd by Registrar) (b) Huntington Millington, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5th 1947, at 4.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/30th 1947 to 4/5th 1947 and that I last saw h[illegible] alive on 4/5th 1947.

Immediate cause of death	Duration
Pulmonary Edema	2 days
Due to Cardiac Vascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. J. Fowler M. D.

Address 100 N Milton Date signed 4/7/47

G50411

JL - 105271 007

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G50411

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 - 20
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 Spray Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Daniels

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Allie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 23, 1916

8. AGE: Years	Months	Days	If less than one day
30	5	12	hr. min.

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John
13. Birthplace N. C.

MOTHER
14. Maiden Name Anna Daniels
15. Birthplace N. C.

16 (a) Informant N. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Greenmount Location N. C.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1911 Pulaski St.

19 APR 7 1947 (Date rec'd by registrar) (b) Huntingtown, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5, 1947, at 8:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 15 1946 to April 5 1947 and that I last saw h. 1[illegible] alive on April 5 1947

Immediate cause of death

	Duration
Respiratory Failure	1-day
Due to Pulmonary Tuberculosis	Months
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Laurence Lee M. D.
Address Baltimore City Hospitals Date signed 4-6-47

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50412 420.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G50112

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1822 No Payson St (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Cohen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Millie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15-1887

8. AGE: Years 59 60 | Months 6 | Days 20 | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name unknown
13. Birthplace Poland

MOTHER
14. Maiden Name unknown
15. Birthplace Poland

16 (a) Informant Millie Cohen
(b) Address 1822 No Payson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-7-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phila. Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
Address 1419 E Balto St

19 (a) APR 7 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5, 1947, at 7 50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 5 1947 to April 5 1947, and that I last saw him alive on April 5 1947

Immediate cause of death	Duration
Cardiac failure	
Due to Myocardial infarction	
Due to Coronary sclerosis Generalized arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sydney Green M. D.
Address Sinai Hospital Date signed 4-7-47

V S 150

G50413 490

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1084

Registered No. G50413

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hosp. 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. New Rhemont Hotel - Balto.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Leon Krantz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1903

8. AGE: Years	Months	Days	If less than one day
44	6		hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Cab driver

11. Industry or business

FATHER 12. Name unknown
13. Birthplace Russia

MOTHER 14. Maiden Name [illegible]
15. Birthplace Russia

16 (a) Informant Son Lewis
(b) Address 1429 N. Carlton St.

17 (a) Burial (b) Date thereof 4-7-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto Hebrew
Location Belgian Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 1429 E Balto St

APR 7 1947 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/4 1947, at 3 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1 1947 to 4/4 1947, and that I last saw him alive on 4/4 1947.

Immediate cause of death	Duration
(a) Lung failure	
Due to (b) Pneumonia	
Due to (c) Chronic bronchitis	over
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arnat Thiel M.D.
Address Mercy Hosp Date signed 4/4/47

VS 150

G5D114

1672

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

Registered No. G5D114

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4013 Liberty Heights Ave.
(c) Hospital or institution:
Alberta Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6 W. Oliver St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAUDE GUNTHER

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife: Robert C. Gunther
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 21, 1875

8. AGE: Years	Months	Days	If less than one day
72	0	13	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name - Pruitt
13. Birthplace Unknown

MOTHER
14. Maiden Name Barsheba -
15. Birthplace Unknown

16 (a) Informant Mr. R. C. Gunther, husband
(b) Address 6 W. Oliver St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/7/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

APR 7 1947 (Date rec'd by registrar) (b) Williamsport, Md. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 22nd 1945, to April 4th 1947, and that I last saw h.e alive on April 3rd 1947.

Immediate cause of death: Heart Failure — Duration: 1 week
Due to Carcinoma of Lung — 2 years
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature J. E. Poulton
Address 3904 Gamon Blvd Date signed 4/4/47

VS 150

Thurlington Williamsport Md.

X

G50115

420.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G50115

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1512 E. Lanvale
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 65 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1512 E. Lanvale Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Nennstiel

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: John Nennstiel
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) June 25th, 1875

8. AGE: Years 71 | Months 9 | Days 8 | If less than one day ######## min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Graser
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Eva Weigel
15. Birthplace Germany

16 (a) Informant Mr. Frank Sanders
(b) Address 1512 E. Lanvale Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/7/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave., Balto: Co.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (c) APR 7 1947 Huntington Millspaugh M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3rd 1947, at 3 00 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1947 to April 3 1947 and that I last saw her alive on April 2 1947

Immediate cause of death: Coronary occlusion — Duration: 3 Days
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature W. D. Graser
Address 1402 E. Lanvale Date signed 4.5.47

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C50416 422.1 BALTIMORE CITY HEALTH DEPARTMENT 937 Registered No. C50416

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3702 Frankford Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3702 Frankford Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE WEST

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	Widowed

6 (b) Name of husband or wife John West
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1880

8. AGE: Years	Months	Days	If less than one day
67	1	20	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Wright
13. Birthplace Virginia

MOTHER
14. Maiden Name Not Known
15. Birthplace Virginia

16 (a) Informant Mr. James J. O'Connor
(b) Address 3702 Frankford Ave. - 6

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 7, 1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md.

18 (a) Funeral director HENRY SANDER & SONS. INC.
(b) Address Baltimore Md.

APR 7 1947 (Date rec'd by registrar) (b) Huntington Williams M. D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4, 1947 at 10.25A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mch 20 1947, to April 4 1947, and that I last saw her alive on April 4 1947

Immediate cause of death	Duration
Edema of Lungs	2 days
Due to Chronic Myocarditis	5 yrs
Due to	
Other Conditions Arterio Sclerosis	10 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Gill Wall M. D.
Address 1631 E. North Ave Date signed 4/5/47

X

G50117

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5021 106 B

Registered No. G50117

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3137 Elliott St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 50
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Md.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3137 Elliott St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Malczewski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Veronica

6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Feb. 22 1879

8. AGE: Years 68 | Months 1 | Days 12 | If less than one day: hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Pinshon

11. Industry or business Continental Can

FATHER 12. Name Unknown

FATHER 13. Birthplace Germany

MOTHER 14. Maiden Name Unknown

MOTHER 15. Birthplace Germany

16 (a) Informant Mrs. Veronica Malczewski

(b) Address 3137 Elliott St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/10/47 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary

Location Germak Hill Rd.

18 (a) Funeral director Marie E. Fiolkowski

(b) Address

19 (a) APR 7 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1947 at 11:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 2 1947 to April 6 1947, and that I last saw h im alive on April 5 1947.

	Duration
Immediate cause of death: Chronic bilateral bronchiris	1
Due to Myocardial insufficiency	5 days
Due to Arterio-sclerosis	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

Signature Benedict Bronushas, M. D. M. D.

Address 3037 O'Donnell St Date signed APR 7 1947.

VS 150

G50418 187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 518

Registered No. G50118

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address MONUMENT ST. AND B'WAY.
(c) Hospital or institution:
SINAI HOSPITAL 71
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) 65 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 724 W. HAMBURG ST.
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM E. EARLE

3 (b) If veteran, name war —

3 (c) Social Security Account No. 214-03-2421

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife BERTHA EARLE
6 (c) If alive, give age 7, years

7. Birth date of deceased (mo., day, yr.) NOV 16 1881

8. AGE: Years	Months	Days	If less than one day
65	4	21	..... hr. ..... min.

9. Birthplace BALTO MD.
(Town, county, and state)
10. Usual Occupation CLERK. TOOL ROOM
11. Industry or business CONTINENTAL CAN CO

FATHER
12. Name Not known
13. Birthplace Not known

MOTHER
14. Maiden Name Not known
15. Birthplace Not known

16 (a) Informant Bertha Earle
(b) Address 724 W Hamburg St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 9-47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto Md

18 (a) Funeral director Bernard E Hartig
(b) Address 121 E West St

19 (a) APR 7 1947 (Filed by registrar) Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 19 47, at 1:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from MARCH 21 19 47 to APRIL 7 19 47, and that I last saw him alive on APRIL 6 19 47

Immediate cause of death UREMIA — Duration

Due to RENAL INSUFFICIENCY

Due to METASTATIC CARCINOMA OF THE PROSTATE

Other Conditions HYPERTENSION AND GENERALIZED ARTERIOSCLEROSIS

(Include pregnancy within 3 months of death)

Date of operation BRONCHO PNEUMONIA

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel Lerman
Address Sinai Hospital Date signed M. 4 D. 7-47.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50119 4201 Kosmaczewski

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G50119

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 125 S Amm St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 125 S. Amm St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amma Kosmaczenski (Kosmasinke)
3 (b) If veteran, name war
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Julian
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years	Months	Days	If less than one day
61			hr. min.

9. Birthplace Poland (Town, county, and State)
10. Usual Occupation House Work
11. Industry or business at Home

FATHER
12. Name Alexander Redyk
13. Birthplace Poland

MOTHER
14. Maiden Name Mrk
15. Birthplace Poland

16 (a) Informant Stanley Kosmaczenski
(b) Address 1255 Amm St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 8/47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Ozaczenski
(b) Address 1930 Eastern Ave

APR 7 1947 (Date rec'd by Registrar) (b) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1947, at 4:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 11 1947 to April 4 1947
and that I last saw h[illegible] alive on April 4 1947

Immediate cause of death

	Duration
Coronary Thrombosis	7 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wayne L. Solomon
Address 127 S. Bway Date signed 4/5/47

VS 150

G50420 420.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G50420

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 709 W 36th St.
(c) Hospital or institution:
13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 709 W 36th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Muriel F. Martin

3 (b) If veteran, name war —

3 (c) Social Security Account No. 717-07-8743

4. Sex male | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Myrtle P. Martin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 3 1889

8. AGE: Years 57 | Months 8 | Days 1 | If less than one day hr. min.

9. Birthplace Maryland. (Town, county, and state)

10. Usual Occupation Engineer

11. Industry or business Penna R.R.

FATHER 12. Name A. Martin

13. Birthplace Maryland.

MOTHER 14. Maiden Name Clara V. Martin

15. Birthplace Maryland.

16 (a) Informant Myrtle P. Martin

(b) Address 709 W 36th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 7/47 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location

18 (a) Funeral director Chenoweth & Donovan

(b) Address 3615-17 Chestnut Ave.

19 (a) (b) Huntington Williams M.D.

APR 7 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4, 1947, at 10 55 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1946 to 4/4 1947, and that I last saw h alive on 3/31 1947.

Immediate cause of death Coronary Occlusion — Duration 0

Due to Arterio Sclerosis — Duration 4 yrs.

Due to — Duration

Other Conditions Over weight.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. Clark Huntington M.D.
Address 2020 W. Cleary Date signed 4/4/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C50121

CWK-109605 260

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

Register C50121

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Days
72- 4- 22-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 345 S. Bouldin Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Stemmer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Adam
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 18-1874

8. AGE: Years	Months	Days	If less than one day
72	4	22	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Henry Bremer
13. Birthplace Germany

MOTHER
14. Maiden Name Johanna dont Knar
15. Birthplace Germany

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof April 7-
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Rural

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2400 E. Oregon St

19 APR 7 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH April 5 1947, at 11:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 2 1947, to Apr. 5 1947, and that I last saw her alive on Apr. 5 1947

Immediate cause of death	Duration
Cerebral Hemorrhage	Few days
Pulmonary Edema	1 day
Due to Hypertensive Cardiovascular Disease	?
Due to	
Other Conditions Diabetes Mellitus	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.
Address Baltimore City Hosp. Date signed 4-6-47

VS 150

93D

G50122
5/2987 261

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓61

Registered No. G50122

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1935 Orleans St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Whalen

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife John A Whalen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-11-10

8. AGE: Years	Months	Days	If less than one day
36	8	25	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business At Home

FATHER 12. Name Horace Sullivan
13. Birthplace Md

MOTHER 14. Maiden Name Mary McCoy
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 8 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem City
Location

18 (a) Funeral director Wilson Funeral Home
(b) Address 200 E Orleans St

19 APR 7 1947 (b) Huntington Williams M.D.
(Date rec'd by Registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1947, at 1125 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 5 1947, to April 5 1947, and that I last saw h[illegible] alive on April 5 1947.

Immediate cause of death	Duration
Diabetic Acidosis	24 hrs.
Due to	
Due to	
Other Conditions Acute Hemorrhagic Prostatic	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Truman D. Gentzler M. D.
Address Johns Hopkins Hosp Date signed 4-6-47

VS 190

X

G50123 420.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G50123

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 14 Midvale Road
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 14 Midvale Road
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Isa Manning Parsons
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Margaret Brian
6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1867

8. AGE: Years	Months	Days	If less than one day
79	6	27	hr. min.

9. Birthplace Frederick, Md.
(Town, county, and state)
10. Usual Occupation Pres., J.E.Hurst & Co.
11. Industry or business retired 12 years

FATHER
12. Name Simon Parsons
13. Birthplace Frederick County, Md.

MOTHER
14. Maiden Name Harriet
15. Birthplace Frederick, Md.

16 (a) Informant I. Manning Parsons, Jr.
(b) Address 800 Saint George's Road

17 (a) Burial (b) Date thereof 4/9/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 APR 7 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1947, at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 22 1941, to April 6 1947, and that I last saw him alive on April 6, 1947

Immediate cause of death	Duration
Coronary occlusion (thrombosis)	Few hours
Due to Arteriosclerosis	
Due to	
Other Conditions Fever	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operations: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —
23. Signature John Tilden Howard M. D.
Address 18 E. Eager St. Date signed Apr. 7, 47

VS 150

Dr John T. Howard X

G50424 · 442.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G50424 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 119 Bellemore Road
(c) Hospital or institution:
none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 119 Bellemore Road
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Lucy Richardson Downes

3 (b) If veteran, name war.

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Edwin R. Downes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 27, 1869

8. AGE: Years	Months	Days	If less than one day
78	1	10 ?	hr. min.

9. Birthplace Denton, Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name William P. Richardson
13. Birthplace Denton, Md.

MOTHER
14. Maiden Name Anna Reyner
15. Birthplace Denton, Md.

16 (a) Informant Mrs. Edwina D. Ruhl
(b) Address 119 Bellemore Road

17 (a) Burial (b) Date thereof 4/9/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Denton
Location Denton, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 APR 7 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1947, at 11 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1947 to April 6 1947, and that I last saw h. alive on April 6 1947

Immediate cause of death Uremia. — Duration 14 days

Due to Hypertensive Arteriosclerotic Cardio Vascular Renal Disease — Duration years

Due to — Duration

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lauriston L. Downes M. D.
Address 1938 Linden Ave. Date signed 7 Apr/47

Dr. Lauriston L. Downes

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G50425 450 /97 Reg. G50425

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1313 Mt. Royal Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1313 Mt. Royal Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucie V. Menke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Henry G.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9, 1870

8. AGE: Years	Months	Days	If less than one day
76	10	27	hr. min.

9. Birthplace New Market Va. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Va.

MOTHER
14. Maiden Name Not Known
15. Birthplace Va.

16 (a) Informant Edith B. Talbott
(b) Address 1313 Mt. Royal Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/7/47 (month) (day) (year)
(c) Cemetery or crematory Fort Lincoln
Location Washington Blvd.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) APR 7 1947 Date rec'd by registrar (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/5/ 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/2 1947, to 4/5 1947, and that I last saw her alive on 4/4 1947

Immediate cause of death Myocardial failure — Duration

Due to arterial sclerosis

Due to senility

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.

Address 1123 St Paul St Date signed

G50426 261

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G50126

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Glenarm, Maryland (If outside city or town limits, write RURAL and give town)
(d) Street No. Hines Rd. & Simms Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Edna Luskorn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Frank M. Luskorn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14th, 1902

8. AGE: Years	Months	Days	If less than one day
45	1	22	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Walter Botler
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Carrie Barnhaus
15. Birthplace

16 (a) Informant Mr. Frank M. Luskorn
(b) Address Hines Rd. & Simms Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 4/9/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director Lassahn Funeral Home
(b) Address 2401 Belair Road

19 (a) APR 7 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-6-47 19 , at 10 05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-30-1947 to 4-6-1947 and that I last saw her alive on 4-6-1947

Immediate cause of death: Respiratory failure — Duration
Due to Coronary Thrombosis ??
Due to Diabetic Coma
Other Conditions Possible pneumonia, ? Uremia
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Lacey
Address Univ. Hosp. Date signed 4-7-47

VS 150

G50427 443.1 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 1937 Registered No. G50427

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 608 Jasper St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 608 Jasper St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME MARY BRIGGS

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife Walter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/3/1889

8. AGE: Years	Months	Days	If less than one day
58	3	1	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business Cook

FATHER
12. Name John Johnson
13. Birthplace Md

MOTHER
14. Maiden Name Sophia
15. Birthplace Md

16 (a) Informant Pearl Hill (Niece)
(b) Address 528 N. Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/7/1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Galvary
Location A.A. County, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N. Carrollton Ave

APR 7 1947 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH 4/4/1947 19..., at 3:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/26/1947 to 4/4 1947 and that I last saw h[illegible] alive on 4/4 1947.

Immediate cause of death	Duration
(a) Mitral Insufficiency	3 yrs
Due to (b) Hypertension	
Due to (c) Cerebral Vascular Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. W. Neuffer M.D.
Address 526 N. Fulton Ave Date signed 4/7/47

X

G50128 420.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G50128

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 417 Wilson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 417 Wilson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Kaminsky

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Fannie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 70 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Grocers

11. Industry or business

FATHER
12. Name unknown
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Mae Kaminsky
(b) Address 4036 Boarman Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-8-47 (month) (day) (year)
(c) Cemetery or crematory Southern Ave Cem
Location Henry Lane

18 (a) Funeral director Jack Rebiz Inc
(b) Address 1426 E Balto St

19 (a) APR 7 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6th 1947, at 7:30 P.M.

21. I certify that I took charge of the remains described above, held an Aug Ed Insp thereon and from the evidence obtained
Autopsy / Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William L Hetrick M.D.
Medical Examiner.
Date signed April 7th 47

VS 191

G50429 4431

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G50429
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry of the causes of death clearly and legibly. correct age is especially important. Physicians: please write the c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 209 Hollinton St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Melvin L. Hahn

3 (b) If veteran, name war No. | 3 (c) Social Security Account No. None.

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Amanda L. Hahn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar-15-1871

8. AGE: Years 76 | Months 7 | Days 20 | If less than one day hr. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual Occupation Farmer Retired

11. Industry or business

FATHER
12. Name John H. Hahn
13. Birthplace

MOTHER
14. Maiden Name Ida Stitely
15. Birthplace

16 (a) Informant Floyd L. Hahn
(b) Address 28 So. Elliott Driveway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 8-1947 (Month) (Day) (Year)

(c) Cemetery or crematory Loudon Park
Location Balto Md

18 (a) Funeral director Peter J. Kelly
(b) Address 2301 W. Baltimore St.

19 (a) (Date received by Registrar) APR 7 1947 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5-6 1947, at 10:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-17 1941, to 4-5 1947, and that I last saw h[illegible] alive on 4-5 1947.

Immediate cause of death	Duration
Hypertension C-V-D with Congestive Heart Failure	6 years 3 months
Due to	
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: Not Done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leo Ashman M. D.
M. D.
Address 1201 Poplar Grove St Date signed 4-6-47

G50430 341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G50430

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 726 Bruce St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 726 Bruce St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucy Lucille Talbott

3 (b) If veteran, name war /
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	married

6 (b) Name of husband or wife Frank Talbott
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-7-1889

8. AGE: Years	Months	Days	If less than one day
57	4	26	hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name William King
13. Birthplace Va

MOTHER 14. Maiden Name ?
15. Birthplace

16 (a) Informant Frank Talbott
(b) Address 726 Bruce St

17 (a) Burial (b) Date thereof 4/7/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Star
Location Md

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Pressstman St

19 1947 (b)
(Date rec'd by registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1947 at 2.05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-18 1947 to 4-3 1947 and that I last saw h.. alive on 4-1 1947

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Arteriosclerosis	1 yr
Due to	
Other Conditions Arthritis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Atwell Jones M. D.
Address 5 S Wolfe St Date signed 4-5-47

Huntington Williams, M.D.

X

G50431

BCHF 77576

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

181

Registered No. G50431

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — 448 E 90E
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1365 N. Stricker
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John L. McLeod

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race Col.

6 (a) Single, married, widowed, or divorced. Child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-11-1943

8. AGE: Years 4 | Months | Days | If less than one day hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Booker T. McLeod
13. Birthplace S.C.

MOTHER
14. Maiden Name Nettie Chapman
15. Birthplace S.C.

16 (a) Informant Booker T. McLeod
(b) Address 332 Presstman St

17 (a) Burial (b) Date thereof 4-7-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Md.

18 (a) Funeral director Geo. D. Kelson
(b) Address 1303 Presstman St

19 (a) 1947 (b) Washington Williams, Registrar
(Date rec'd by reg.)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/3 1947, at 2:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/4 1947, to 4/3 1947, and that I last saw him alive on 4/3 1947.

Immediate cause of death: Surgical Shock — Duration

Due to: 2nd & 3rd degree burns of legs & lower back

Due to: Pneumonia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 4/3/47

Major findings of operation: Split Skin graft

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 15/1
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 3-4-47 at A. M
(c) Where did injury occur? 1365 N. Stricker St. Balto Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Means of injury Clothes ignited from gas range

23. Signature H. A. Shallenberger M.D.

Address University Hospital Date signed 4-3-47

VS 150

Undertaker - take this slip to Medical Examiners Office for O.K.

A. A. Merrill MD

G50432

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

420.1 94a

G50432
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cause and age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5118 Reisterstown Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5118 Reisterstown Rd.
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Frisch

3 (b) If veteran, name war
(c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of ~~husband or~~ wife Edith Frisch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1873

8. AGE: Years	Months	Days	If less than one day
73	11	25	hr. min.

9. Birthplace Hungary
(Town, county, and state)
10. Usual Occupation Prop. Grocery
11. Industry or business Store

FATHER
12. Name Herman Frisch,
13. Birthplace Hungary.

MOTHER
14. Maiden Name Unknown
15. Birthplace Hungary

16 (a) Informant Mrs. Jeannette Moore
(b) Address Villa Nova Rd.

17 (a) Burial (b) Date thereof 4/8/47.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Hebrew Friendship
Location Bayside, Md.

18 (a) Funeral director Chas. Sonnheim & Son
(b) Address 120 E. Eutaw Place

19 (a) APR 7 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1947, at A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 19 to 4/5/47 19.
and that I last saw h~~im~~ alive on 4/4/47 19.

Immediate cause of death	Duration
Interstitial Pneumonia	4 yrs
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Queen Brown Tee
Address 2904 Reisterstown Rd. Date signed 4/5/47

VS 150

G50433 820 E902

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G50133 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave
(c) Hospital or institution: Sinai Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City ~~or town~~ Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Marlborough & Gay Sts.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME GILBERT COBLENS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 23 1875

8. AGE: Years	Months	Days	If less than one day
72	2	14	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Abram Coblens
13. Birthplace

MOTHER
14. Maiden Name Rachel Weillers
15. Birthplace Balto. Md.

16 (a) Informant Mr. Calvert Cahn
(b) Address Temple Garden Apts.

17 (a) Burial (b) Date thereof 4/8/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Chevt Shalom
Location Balto. Md.

18 (a) Funeral director David Sondheim & Son
(b) Address 1922 Eutaw Place

19 (a) APR 7 1947 (b) Harrington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1947 at 8:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 12 1947 to April 6 1947 and that I last saw h~~im~~ alive on April 6 1947

Immediate cause of death — [redacted]
Cardiac insufficiency
Due to Fracture of right hip
Due to —
Other Conditions Hypertension cardio-vascular disease
(Include pregnancy within 3 months of death)
Date of operation March 14, 1947
Major findings of operation: Subcapital fracture of hip
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 3-10-47 at M
(c) Where did injury occur? Walbrook Junction Balto. Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? public (Specify type of place) While at work? no
(e) Means of injury Fell while walking across street

23. Signature Allen A. Merritt M.D.
Address Sinai Hospital Date signed 4-6-47

Howard J. Moersberg M.D.

V S 150

G50434 (1182) BALTIMORE CITY HEALTH DEPARTMENT G50434

CERTIFICATE OF DEATH 1/3B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1431 W. Franklin Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto., (If outside city or town limits, write RURAL and give town)
(d) Street No. 1431 W. Franklin Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RAYMOND BROWN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 9 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park,
Location

18 (a) Funeral director Wilmer Farris Co
(b) Address 432 Park Ave. Bal. Md.

19 (a) 4-7-47 (Date received by registrar) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6, 1947, at 4:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Pulmonary tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Rogers M.D.
Medical Examiner.
Date signed

X

G50435 422.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (1937)

G50435 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Wheeler Nursing Home
(a) Baltimore City, Maryland
(b) Street address 1700 Park Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3mos 8days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town West River Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Woollen Clayton (Martha Woollen Clayton)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife John Clayton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6-1866

8. AGE: Years	Months	Days	If less than one day
80	9	0	hr. min.

9. Birthplace Harwood Md. (Town, county and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Jacob Rogers Woollen
13. Birthplace Baltimore Co. Md.

MOTHER
14. Maiden Name Virginia Clayton
15. Birthplace Harwood Md.

16 (a) Informant Mrs Jos. Bagnell
(b) Address 729 St Johns Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-8-47 (month) (day) (year)
(c) Cemetery or crematory Christ Church Cem
Location Owensville Md

18 (a) Funeral director E. Wallis Lamoreaux
(b) Address 1003 W. Baltimore St

19 (a) (Date rec'd by registrar) (b) Registrar

APR 7 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1947, at 2 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1937 to Apr 6 1947, and that I last saw her alive on 4/5 1947.

Immediate cause of death Myocarditis
Arterio-Sclerosis

Duration
Several

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W H Grady

Address 140 S Park Ave Date signed 4/5/47

X 4/5/47

G50436 0882

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 13B

Registration No. G50136

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution: Church Home & Hospital

(d) Length of stay in hospital or inst. (yrs., ~~months~~ days) 44
(e) Length of stay in Baltimore (yrs., ~~months~~ days) 42

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5633 Reisterstown Rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Richard Frank Warren

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Mildred N. Warren
6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) Feb'y 4, 1901

8. AGE: Years	Months	Days	If less than one day
46	1	22	..... hr. ..... min.

9. Birthplace Cape Charles, Virginia
(Town, county, and state)
10. Usual Occupation Retired Restaurant & Bar
11. Industry or business Business

FATHER
12. Name Wesley C. Warren
13. Birthplace Cape Charles Va.

MOTHER
14. Maiden Name Bertha, Twiford
15. Birthplace Va. Va.

16 (a) Informant wife
(b) Address 5633 Reisterstown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/9/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 APR 7 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1947, at 2:35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 21 1947, to Apr. 6 1947, and that I last saw him alive on Apr. 5 1947.

Immediate cause of death	Duration
Advanced Pulmonary Tuberculosis	2 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John A. Rowe M.D.
Address Church Home & Hosp. Balto 1 Date signed April 7 1947

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50137 4341 BALTIMORE CITY HEALTH DEPARTMENT G50137
CERTIFICATE OF DEATH 93E Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2701 Garrison Blvd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2701 Garrison Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RICHARD KUTZLEB, Sr.

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Martha A. Kutzleb
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 23, 1868

8. AGE: Years 78 | Months 7 | Days 14 | If less than one day ... hr. ... min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Rubber Co. Representative

FATHER
12. Name August Kutzleb
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Schmied
15. Birthplace Germany

16 (a) Informant Mr. August Kutzleb
(b) Address 104 Park Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/8/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

APR 7 1947

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6, 1947 at 9:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-1-1947 to 4-6-1947 and that I last saw him alive on 4-5-1947.

Immediate cause of death	Duration
Acute Congestive heart	2 hr
Due to Cirrhosis	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry E. Warren M. D.
Address 2604 Garrison Blvd. Date signed 4-7-47

G50138

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

196 55 B

Registered No. G50138

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4335 Park Heights Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4335 Park Heights Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN M. STIMMEL

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	191-10-8968

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Alice Elaine Stimmel (nee Gribble) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 24, 1876

8. AGE: Years	Months	Days	If less than one day
70	7	11 12	hr. min.

9. Birthplace Damson, Pa.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business B. & O

FATHER
12. Name Wm. Stimmel
13. Birthplace -

MOTHER
14. Maiden Name Annabelle Moreland
15. Birthplace Pa.

16 (a) Informant Mrs. Alice E. Stimmel
(b) Address 4335 Park Heights Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4/8/47 (month) (day) (year)
(c) Cemetery or crematory Baldwin Cem.
Location Steelton, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) APR 7 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5, 1947, at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1st 1941 to April 5 1947 and that I last saw h[illegible] alive on April 4 1947.

Immediate cause of death SARCOMA of FEMUR — Duration 2 years

Due to Ischial Metastasis — Duration 4 yrs

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alex A Weinstock M. D.
Address [illegible] Date signed 4/7/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C50139 019.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

Registered No. C50139

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rudwood & Druro Sts
(c) Hospital or institution University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 517 Orchard St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Albert Carroll

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15, 1927

8. AGE: Years 19 | Months 8 | Days 18 | If less than one day ..... hr. ..... min.

9. Birthplace Jessup, Howard Co., Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Ernest Carroll

13. Birthplace Jessup, Howard Co. Md.

MOTHER 14. Maiden Name Mary Robinson

15. Birthplace Jessup Howard Co. Md

16 (a) Informant Mary Carroll

(b) Address 517 Orchard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-9-1947 (month) (day) (year)

(c) Cemetery or crematory Asbury Methodist

Location Jessup, Howard Co. Md.

18 (a) Funeral director Mrs. Katie R. Williams

(b) Address 322 N. Schroeder St.

19 (a) APR 7 1947 (Date rec'd by Local Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1947, at 12 05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1947 to April 5 1947 and that I last saw him alive on April 4 1947

Immediate cause of death Pulmonary Tuberculosis — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Charles R. Holmes

Address University Hosp. Date signed 4/5/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50440

341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G50440

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 501 N Fremont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Blise Ballanger

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	married

6 (b) Name of husband or wife Gertrude Ballender
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20 1892

8. AGE: Years	Months	Days	If less than one day
55		15	hr. min.

9. Birthplace S.C. (Town, county, and state)
10. Usual Occupation Laborer.
11. Industry or business

FATHER
12. Name Ballender
13. Birthplace Greer, S.C.

MOTHER
14. Maiden Name Ida Drummond
15. Birthplace Greer, S.C.

16 (a) Informant Gertrude Ballender
(b) Address 501 N. Fremont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-8-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Willis
(b) Address 3911 W. Schroeder St.

19 (a) APR 7 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 4 1947, at 9:45 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D. Medical Examiner.
Date signed 4/5/47

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50141 261

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

Register G5D141

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens
(c) Hospital or institution: St Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days) Cable
(e) Length of stay in Baltimore (yrs., mos., or days) 7

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 28 Harlem Lane (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Susan Hipsley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife James E. Hipsley 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 28 1861

8. AGE: Years 85 | Months 3 | Days 7 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business House work

FATHER 12. Name Edward Trevor

13. Birthplace England

MOTHER 14. Maiden Name Mary Hiett

15. Birthplace Scotland

16 (a) Informant Mrs Mildred Reich

(b) Address 28 Harlem Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 8 1947 (month) (day) (year)

(c) Cemetery or crematory Loraine

Location Bare to Co

18 (a) Funeral director Lyle S May Nabb

(b) Address Catonsville Md

19 APR 7 1947 (Date rec'd by Local Reg.) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/4 1947, at 6.35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/4/47 19 to 4/4/47 19; and that I last saw her alive on 4/4/47 19

Immediate cause of death Coronary failure — Duration

Myocardial fibrosis — Duration

Due to Diabetes Mellitus — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard W. Hunter

Address St Agnes Date signed 4/4/47

G50442 820 E902

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓ 186a

Registered No. G50142

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore 7
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5615 Penn Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annah Boteler

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Albert Eugene Boteler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 30/1854

8. AGE: Years	Months	Days	If less than one day
92	7	7	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name James D. Streets
13. Birthplace Delaware

MOTHER
14. Maiden Name Mary Jane Johnson
15. Birthplace Baltimore Md.

16 (a) Informant Albert G Boteler
(b) Address 5615 Pen park Ave

17 (a) Burial (b) Date thereof Apr 9/1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.
18 (a) Funeral director Harry A. Annacost
(b) Address 4204 Ridgewood Ave
19 (a) Received by registrar (b) Registered APR 7 1947 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1947, at 12:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 4 1947, to April 6 1947, and that I last saw h[illegible] alive on April 5 1947.

Immediate cause of death Pneumonia	Duration
Due to	
Due to	
Other Conditions Fracture left hip (2) Cardiac decompensation	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 28/2
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 3-2-47 at ? M
(c) Where did injury occur? 5615 Penn Park Ave
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Slipped & fell to floor

23. Signature Edward P Smith M. D.
Address Mercy Hospital Date signed 4-6-47
Howard J. Mendzin, M.D.

MARGIN RESERVED — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C50143 305

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. C50143

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — Mt. St. Agnes Convent
(b) Street address — Mount Washington
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) — 27-15
(e) Length of stay in Baltimore (yrs., mos., or days) — 61 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State — Maryland (b) County — ---
(c) City or town — Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. — --- (If rural give location)
(e) Citizen of foreign country? — --- (Yes or No)
If yes, name country — ---

3 (a) FULL NAME — Sister Mary deSales Burke

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex — Female
5. Color or race — White
6 (a) Single, married, widowed, or divorced. — Single
6 (b) Name of husband or wife — ---
6 (c) If alive, give age -- years
7. Birth date of deceased (mo., day, yr.) — May 19, 1885
8. AGE: Years 61 | Months 10 | Days 17 | If less than one day -- hr. --- min.
9. Birthplace — Baltimore, Maryland (Town, county, and state)
10. Usual Occupation — Sister of Mercy
11. Industry or business — ---

FATHER
12. Name — Michael Burke
13. Birthplace — Baltimore, Maryland

MOTHER
14. Maiden Name — Anna ---
15. Birthplace — Baltimore, Maryland

16 (a) Informant — Sister Mary Ellen Marie
(b) Address — Mt. St. Agnes' Convent

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/8/47 (month) (day) (year)
(c) Cemetery or crematory — Mt. St. Agnes
Location — Mt. Washington

18 (a) Funeral director — H. W. Meats and Son
(b) Address — 805 N. Calvert Street

19 (a) APR 7 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH — 6 April 1947, at 5:02 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from January 1947 to 6 April 1947 and that I last saw her alive on 3 April 1947

	Duration
Immediate cause of death — Exanition	2 hrs
Due to — Pneumonia	1 day
Due to — Pre-Senile Cerebral Arterio-sclerosis	2 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature — J. Edwin Muller, M.D.
Address — 2 W. Read St. Date signed — 6 April 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G50144 443.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G50144

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2667 N. Benedict St.
(c) Hospital or institution
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2667 N. Benedict St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie S. McGraw

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 25, 1884

8. AGE: Years 63 | Months | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (town, county, and state)
10. Usual Occupation House work
11. Industry or business at home

FATHER
12. Name Jeremiah M. Grow
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Alice M. Sheary
15. Birthplace Baltimore, Md

16 (a) Informant Mrs. Leona Hamm
(b) Address 2566 Fulton Street

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 4/10/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Road

18 (a) Funeral director Wm. Cowan & Son
(b) Address 1107-09 Hollins St.

19 APR 7 1947 (Date rec'd by registrar) Huntington Williams, M. D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/7/1947, at 2:45 M

21. I certify that death occurred on the date above stated, that I attended deceased from April 3 1947, April 7 1947, and that I last saw h-e- alive on April 6 1947.

Immediate cause of death: Hypostatic Congestion
Due to: Chronic Cystitis
Due to:
Other Conditions: Pulmonary Oedema
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

	Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert C. Peters, M. D.
Address 915 Hollins Ave Date signed 4/7/47

G50145 581.0

BALTIMORE CITY HEALTH DEPARTMENT X 1243

CERTIFICATE OF DEATH

Registered No. G50145

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Hamperet Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town ~~Balto~~ Middle River
(If outside city or town limits, write RURAL and give town)
(d) Street No. 933 Wampler Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Huber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Mary Huber
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 21-1868

8. AGE: Years	Months	Days	If less than one day
78	6	12	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Huber
13. Birthplace Not Known

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant George Huber
(b) Address 310 Harding Ave. Middle River

17 (a) Burial (b) Date thereof April 7-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bal. Lawn Mem.
Location Eastern Blvd.

18 (a) Funeral director John F. Miller
(b) Address 2834 Jefferson St.

19 (a) APR 7 19[illegible] Huntington-Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 19 47, at 1 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 10 19 47 to April 3 19 47.
and that I last saw h-in alive on April 2 19 47.

Immediate cause of death Cerebral haemorrhage — Duration 18 hrs
Due to Hypertensive Cardiovascular
Due to disease
Other Conditions Cirrhosis of liver
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. F. Fuller M.D.
Address Rodgers Rd, Baltimore 6 Date signed 4/9/47
M. D.

VS 150

ind X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50446 421-7

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G50446

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Md. Hotel - #306 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harold F. Cusack

3 (b) If veteran, name war: WW I & II
3 (c) Social Security Account No. 112-10-2485

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Laura Dillon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4 1895

8. AGE: Years 49 | Months 1 | Days 21 | If less than one day ... hr. ... min.

9. Birthplace Brooklyn N.Y. (Town, county, and state)

10. Usual Occupation Waiter
11. Industry or business Ford

FATHER
12. Name Wm F Cusack
13. Birthplace Brooklyn N.Y.

MOTHER
14. Maiden Name Francis Miller
15. Birthplace Brooklyn N.Y.

16 (a) Informant
(b) Address

17 (a) Removal (Burial, cremation or removal) (b) Date thereof 4/7/47 (month) (day) (year)
(c) Cemetery or crematory New York National
Location Brooklyn New York

18 (a) Funeral director Ray S. Watkins Funeral Home
(b) Address 4036 E. 25th St

19 (a) APR 7 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1947 at 3 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Koons M.D. Medical Examiner.
Date signed 4-5-47

VS 151

G50147

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G50147
Registered No.

BC# B-74049 491 107

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 415 N. Parrish St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) 19 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 415 N. Parrish St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Richard Jordan Hopper Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	N	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 19 March 1947

8. AGE: Years	Months	Days	If less than one day
		15	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Richard Jordan Hopper
13. Birthplace Baltimore

MOTHER
14. Maiden Name India Turnstall
15. Birthplace Baltimore

16 (a) Informant India Turnstall
(b) Address 415 N. Parrish St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School APR 7 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) APR 7 1947 Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 April 1947, at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-19-1947 to 4-3-1947, and that I last saw h[illegible] alive on 4-2-1947.

Immediate cause of death: Bronchopneumonia — Duration: 10 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William S. Miller M. D.
Address Univ. Hosp. Date signed 4-3-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50148 343

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

G50148 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Market Place Hotel (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Irvin Haddox

3 (b) If veteran, name war: W. W. #1

3 (c) Social Security Account No. 213-[illegible]-2017

4. Sex: Male | 5. Color or race: White | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of husband or wife: IRMA F. HADDOX

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 25th 1898

8. AGE: Years	Months	Days	If less than one day
49	2	10 11	..... hr. ..... min.

9. Birthplace Rhinehart W. Va. (Town, county, and state)

10. Usual Occupation Seaman

11. Industry or business

FATHER
12. Name John Luther Haddox
13. Birthplace W. Va.

MOTHER
14. Maiden Name Rebecca Bates
15. Birthplace W. Va.

16 (a) Informant Mrs. F. J. Dulky
(b) Address 711 S. Highland Ave

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4-8-47 (month) (day) (year)
(c) Cemetery or crematory Baltimore National Lawn
Location Frederick Ave.

18 (a) Funeral director Charles L. Zeiler.
(b) Address 3605 Fait Ave

19 (a) Date rec'd APR 7 1947 (b) [illegible] Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1947 at 2:20 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Edema of brain.
Edema of lungs.
~~Due to~~ Arteriosclerosis.

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 4/1/47

BC# D 80848
G50149 976

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

G50149
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1232 Hull St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Skalstad

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: —

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-1-47

8. AGE: Years — | Months — | Days 5 | If less than one day hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward Skalstad
13. Birthplace Norway

MOTHER
14. Maiden Name Darrza Calendar
15. Birthplace U.S.A.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 4/8/47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem
Location A. A. County

18 (a) Funeral director Charles F. Hill
(b) Address 701 E. Fort Ave

19 (a) (Date rec'd by registrar) (b) (Registrar)

PB 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 6th 1947 at 7:45 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 1 1947 to Apr 6 1947 and that I last saw h alive on Apr. 4 1947

Immediate cause of death	Duration
Respiratory collapse	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugenie Doyle M.D.
M. D.
Address Johns Hopkins Hosp Date signed 4-8-47

VS 150

G50150 BALTIMORE CITY HEALTH DEPARTMENT ✓ G50150
Registered No.

581.0 CERTIFICATE OF DEATH 124a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1714 E. Monument.
(c) Hospital or institution: Sinai Hosp. 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 ds.
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 15 N. Wolfe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES McMannamon. (McMannamon)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1894

8. AGE: Years	Months	Days	If less than one day
62	8	18	hr. min.

9. Birthplace Penna. (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Music Store

FATHER
12. Name James McMannamon
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary McGrain
15. Birthplace Ireland.

16 (a) Informant Wm. A Lehmann
(b) Address 689 Hayle Ave. Ft Lauderdale Fla

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-11-47 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Hanover St

18 (a) Funeral director Elmer St. Cribbin & Son
(b) Address 924 E. Baltimore St Residence Towson, Md.

19 (a) Filed APR 9 1947 (b) Rec'd by (Registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/7 1947, at 5 50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/5/47 1947 to 4/7 1947, and that I last saw him alive on 4/6 1947.

Immediate cause of death Coronary Occlusion
Bronchopneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stanley M. Yaffe, D
Address Sinai Hosp Date signed 4/8/47

X

G50151 CMK-108962 B/H #72560 764.5

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

Registered No. G50151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 28 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 402 N. Durham Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Bracey, (Madeline)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3-1947

8. AGE: Years	Months	Days	If less than one day
0	0	28	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert Lee Bracey
13. Birthplace South Carolina

MOTHER
14. Maiden Name Madeline Hall
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Cremated (b) Date thereof 9am 4-4-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore City Hospitals
Location 4940 Eastern ave.

18 (a) Funeral director
(b) Address

19 APR 8 1947 (b) [illegible]
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1947, at 1:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 3 1947 to April 1 1947 and that I last saw her alive on April 1 1947

Immediate cause of death Duration
Asphyxia 2 hrs.
Due to Prematurity life
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wilson E. Hughes M. D.
Address Balto City Hosp Date signed Apr. 4 '47

VS 150

650452 420.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 650152

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 604 North Eutaw Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Baltimore (b) County Md.
(c) City or town 604 N. Eutaw Street
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Esther S. Coles

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19, 1872

8. AGE 74 Years | 9 Months | 17 Days | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Retired

FATHER
12. Name William Coles
13. Birthplace Maryland

MOTHER
14. Maiden Name Esther Swan
15. Birthplace England

16 (a) Informant George W. Coles
(b) Address 604 N. Eutaw Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/8/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director William Cook
(b) Address 1217 St. Paul Street

19 APR 8 1947 (b) Huntington Mills Registrar
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/6/47 19__, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/6/47 19__ to 4/6/47 19__, and that I last saw h__ alive on 4/6/47.

Immediate cause of death: (a) Coronary Occlusion / 2 Hrs.
Due to: (b) Cerebral Hemorrhage / 2 Hrs.
Due to: (c) Arteriosclerosis / Yrs.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mary C. Howard, M.D.
Address 1626 Mt. Royal Ave. Date signed 4/7/47

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G50453 724 5912 Registered No. G50453

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 440 N. Linwood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town 440 N. Linwood Ave. (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Rodenberg

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Elisabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 27, 1869

8. AGE: Years 77 | Months 5 | Days 8 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace Baltimore, Md.

16 (a) Informant Facol F. Rodenberg
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/9/47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore, Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul Street

19 APR 8 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1947, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1946, to April 5 1947, and that I last saw him alive on April 5 1947.

Immediate cause of death Carcinoma
Antecubitus — Duration

Due to

Due to

Other Conditions Sarcoma Antecubitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jason W. Gaskel M. D.
Address 637 S. Conkling St Date signed 4/7/47

97

G50454 342

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83B

Registered No. G50154

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6028 Old Harford Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town 6 Orkney Court
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Desire A. Irr

3 (b) If veteran, name war: 10
3 (c) Social Security Account No. none

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 21, 1866

8. AGE: Years 80 | Months 5 | Days 15 | If less than one day ..... hr. ..... min.

9. Birthplace France (Town, county, and state or country)
10. Usual Occupation Engraver Retired
11. Industry or business

FATHER
12. Name Eugene Irr
13. Birthplace France

MOTHER
14. Maiden Name Mary Louise Lang
15. Birthplace France

16 (a) Informant Mrs. Helene Sellman
(b) Address 6 Orkney Court

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof 4/8/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul Street

19 APR 8 1947 (b) Huntington for Williamsport
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1947, at 12 01 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 5 1947, to April 6 1947, and that I last saw h.. alive on April 5 1947.

Immediate cause of death	Duration
Cerebral Thrombosis	10 days
Due to Cerebral arteriosclerosis	10 yrs
Due to Senility	10 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 6710 York Rd Date signed April 7 47

X

G50155 — 143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 837

Registered No. G50155

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2510 St. Paul Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2510 St. Paul Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bertha Jane Bennett

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 19, 1858

8. AGE: Years	Months	Days	If less than one day
88	4	17	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Edwin Bennett
13. Birthplace Debershire, England

MOTHER
14. Maiden Name Mary Jane Houston
15. Birthplace E. Liverpool, Ohio

16 (a) Informant Edwin B. Filbert
(b) Address 3525 Newland Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/8/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

APR 8 1947 (Date rec'd by Registrar) [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6, 1947, at 5:08 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/25 1937 to Apr 6 1947, and that I last saw h.m alive on Apr 6 1947.

Immediate cause of death: Hemiplegia — Duration: 3 days

Due to

Due to

Other Conditions: Influenza attack 3/24/47 followed by pneumonia Fatal Relapse 3/31/47
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A Luetcher M. D.
Address 12 Roper St Date signed 4/7/47

X

G50156 | 193 | BALTIMORE CITY HEALTH DEPARTMENT | CERTIFICATE OF DEATH 55E | Registered No. G50156

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3216 Clifton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edgar E. Jones

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widow

6 (b) Name of husband or wife: Ida L. Jones
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 23. 1879

8. AGE: Years	Months	Days	If less than one day
67	5	13	hr. min.

9. Birthplace Lower Marlboro Md (Town, county, and state)
10. Usual Occupation Manager Slat Bowling Alley
11. Industry or business

FATHER
12. Name Thomas Jones
13. Birthplace Lower Marlboro Md

MOTHER
14. Maiden Name Margaret Wood
15. Birthplace Lower Marlboro Md

16 (a) Informant Mrs. Jones
(b) Address 118 Mapleton Towson Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-9-47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Wilson & Son
(b) Address 1217 E Fort Ave

19 (Date rec'd by registrar) APR 8 1947 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-6-1947, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-27-1947 to 4-6-1947 and that I last saw h[im] alive on 4-6-1947

Immediate cause of death	Duration
Respiratory failure	
Due to Carcinomatosis, primary site unknown, ? lung, brain & abdom. visceral involvement.	
Other Conditions Arteriosclerosis Hypotension. CVD	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H Harvey
Address Univ. Hosp Date signed 4-6-47 (M. D.)

VS 150

G50157 592

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

131a

G50157
Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2943 Miles Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2943 Miles Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stephen G. Tracey

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. 215-03-7409

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Bertha M. Tracey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 6, 1882

8. AGE: Years	Months	Days	If less than one day
64	4	0	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Night Watchman
11. Industry or business Potts & Callahan

FATHER
12. Name Daniel Tracey
13. Birthplace Maryland

MOTHER
14. Maiden Name Susan Kramer
15. Birthplace Pennsylvania

16 (a) Informant Bertha M. Tracey
(b) Address 2923 Miles Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/9/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) APR 8 1947 (Registered by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6, 1947, at 7:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 10 1945 to April 6 1947 and that I last saw h alive on April 6 1947.

Immediate cause of death — Duration

Chronic Myocarditis, uncy

Due to

Due to

Other conditions Arteriosclerosis & Chronic Nephritis uncy

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Earl Johnston, M.D.
Address 112 W. 25th St. Date signed April 7, 47

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G50158 422.2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G50158

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1616 Gilmor St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1616 Gilmor St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) **FULL NAME** Eliza Simms (Clark)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1878

8. AGE: Years 69 | Months 1 | Days 18 | If less than one day hr. min.

9. Birthplace Annapolis, Md. (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Charles Davis
13. Birthplace Annapolis, Md.

MOTHER
14. Maiden Name Fannie ?
15. Birthplace West River, Md.

16 (a) Informant Mrs. Tenzina Simmons
(b) Address 726-13th St. Rock Island

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/8/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill Md.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

APR 8 1947 (b) Huntington Williams, M.D. (Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. **DATE OF DEATH** April 2, 1947, at 7-11 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 2, 1947 to Apl 2, 1947 and that I last saw h[illegible] alive on Apl 1, 1947

Immediate cause of death Cerebral Hemorrhage | Duration 1 dy

Due to Chron. Myocarditis, Arteriosclerosis

Due to Senility

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Wm R. Boykin M. D.
Address 1133 Monroe Date signed 4-7-47

X

(R) 0459 CWK-109659 490

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108 Reg. No. 0459

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 9

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
40- 10- 9-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2811 Reese Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Collins

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Separated

6 (b) Name of husband or wife Harry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27 (1908) 1908

8. AGE: Years	Months	Days	If less than one day
39 (40)	10	9	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Coleman
13. Birthplace Maryland

MOTHER
14. Maiden Name Grace Lee
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 10-47 (month) (day) (year)
(c) Cemetery or crematory Arbutus Park
Location Arbutus

18 (a) Funeral director Va Brooks
(b) Address 1463 N. Carey St

19 APR 8 1947 (Date received by Registrar) Huntington-Williams Mfg Co (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 19 47, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 4 19 47, to April 6 19 47, and that I last saw h er alive on April 6 19 47.

Immediate cause of death	Duration
Unknown	
Due to	
Due to Myocardial disease	
Other Conditions Possible pulmonary embolism	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Doyle Waldron M. D.
Address BCH Date signed 4-7-47

VS 150

X

C50160

342

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83c

Registered No. C50160

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4903 Hait ave,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto, (If outside city or town limits, write RURAL and give town)
(d) Street No. 4903 Hait Ave, (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Susie Coleman,

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widowed

6 (b) Name of husband or wife Anthony Jr,

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 14-1876

8. AGE: Years	Months	Days	If less than one day
71	1	18	hr. min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual Occupation at Home

11. Industry or business

FATHER
12. Name Madison Blackburn
13. Birthplace W Va.

MOTHER
14. Maiden Name Caroline Brown
15. Birthplace W. Va.

16 (a) Informant Robert Scott
(b) Address 4903 Hait ave,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/8/47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern ave Rd

18 (a) Funeral director John S Connelly,
(b) Address 418 Eastern Ave Town

19 APR 8 1947 (Date rec'd by registrar) Huntington Williams, Mgr

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/7 1947, at 8.00 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1937, to 4/7/1947, and that I last saw her alive on 3/29/1947

Immediate cause of death	Duration
Uraemia	
Due to Nephrosclerosis	
Due to Senility	
Other conditions Cerebral Softening	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D. Lee Greenfield M. D.

Address 613 East Fayette Date signed 4/8/47

97

G50461

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G50461

BC# D 76019 764.0 1/9a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hosp. 4

(d) Length of stay in hospital or instt. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 741 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Judy Loughry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 22, 1947

8. AGE: Years	Months	Days	If less than one day
		15	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Loughry
13. Birthplace W. Va.

MOTHER
14. Maiden Name Ruth Pennington
15. Birthplace W. Va.

16 (a) Informant William Loughry
(b) Address 741 W. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-8-47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore

18 (a) Funeral director Frederick A. Pope
(b) Address 1700 W. Lombard St

19 (a) Rec'd by (Registrar) (b) Huntington Williams M.D. (Registrar)

APR 9 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/6/ 1947, at 2 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/6/47 19 to 4/6 1947
and that I last saw h CR alive on 4/6 1947

Immediate cause of death	Duration
Cardio - respiratory failure	
Due to Acidosis - Dehydration	
Due to Parenteral Diarrhea	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Evan R. Jennings M. D.
Address Univ. Hosp. Date signed 4/6/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G50162 420.2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G50162

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 Rochester Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 110 Rochester Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Krause

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband ~~or wife~~ Louise
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 5 1866

8. AGE: Years	Months	Days	If less than one day
82	3	1	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Retired Motor Co
11. Industry or business

FATHER
12. Name John Krause
13. Birthplace Germany

MOTHER
14. Maiden Name Lena Goble
15. Birthplace Germany

16 (a) Informant Louise Krause
(b) Address 110 Rochester Place

17 (a) Burial (b) Date thereof April 9 1947 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Druid Ridge Cem
Location Pikesville Md

18 (a) Funeral director John E Horan
(b) Address 3600 Baltimore St

19 (a) Date received by registrar APR 8 1947 (b) Registrar Williams M

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1947 to April 6 1947, and that I last saw h[illegible] alive on April 6 1947.

Immediate cause of death	Duration
(a) Arteriosclerosis	
Due to (b) Hypertension	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 5306 Reisterstown Rd Date signed 4-7-47

G50163

422.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G50163

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3304 Belle Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3000 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Thorne

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Mr. Elizabeth Thorne
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1, 1861

8. AGE: Years	Months	Days	If less than one day
85	9	6 5	hr. min.

9. Birthplace Bufort, N. C. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Teacher

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs Walter B. Simms
(b) Address 3304 Belle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-8-47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md.

18 (a) Funeral director Loving, Byers
(b) Address 5 [illegible] Park, Heights Ave

19 (a) APR 8 1947 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6, 1947, at 11 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 4th 1947, to April 7 1947, and that I last saw him alive on April 6th 1947.

Immediate cause of death	Duration
Cardiac Failure	24 hrs
Due to Myocarditis	1 week
Due to Arteriosclerosis	
Other Conditions Senility	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. J. Boulton
Address 3904 Gunson Blvd Date signed 4-7-47 M. D.

V S 150

G50164 421.4

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1927

Registered No. G50164

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 932 Bennett Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 932 Bennett Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country.

3 (a) FULL NAME Mary Frances Bond Coates

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	Widow

6 (b) Name of husband or wife Raymond Coates
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1, 1896.

8. AGE: Years	Months	Days	If less than one day
50	10	3	hr. min.

9. Birthplace Baltimore, Md.. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Perry ?
13. Birthplace Balto. Md..

MOTHER
14. Maiden Name Agnes ?
15. Birthplace Baltimore Md.

16 (a) Informant Frances Graves.
(b) Address 771 Bradley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-8-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location
18 (a) Funeral director Mrs. Catie P. Walker
(b) Address 322 N. Schroeder St.
19 (a) APR 8 1947 (Date rec'd by Registrar) (b) [illegible] Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1947, at 4:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from January 9 1947 to April 4 1947 and that I last saw her alive on April 2 1947.

Immediate cause of death	Duration
Chronic Endocarditis	—
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. F. Howell M. D.
Address 601 W. Carroll Ave. Date signed 4/8/47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50165 341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 832

Registered No. G50165

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 766 George St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 766 George St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Hester Johnson.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Wilson Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12, 1894

8. AGE: Years 52 | Months 11 | Days 25 | If less than one day ..... hr. ..... min.

9. Birthplace North Thumberland Co. Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Charles Smith.
13. Birthplace Va.

MOTHER
14. Maiden Name Polly
15. Birthplace North Thumberland Co. Va.

16 (a) Informant Mrs. Wilson Johnson.
(b) Address 766 George St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-10-1947 (month) (day) (year)

(c) Cemetery or crematory Mt. Cavalry
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 APR 8 1947 (b) Huntington Williams M.D.
(Date rec'd by local registrar) (Signature)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 7 1947 at 1½ P.M.

21. I certify that death occurred on the date above stated that I attended deceased from Apr 7 1947 to Apr 7 1947 and that I last saw ..... alive on ..... 19..

Immediate cause of death Cerebral Hemorrhage — Duration 7 hrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Williams M.D.

Address 75 W. Franklin Date signed 4/7/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50166 341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

Registered No. G50166

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 919 W. Lexington St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 919 W. Lexington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susie Green

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: C

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Damon Green.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 11, 1898.

8. AGE: Years 48 | Months 5 | Days 25 | If less than one day hr. min.

9. Birthplace Wilmington, N. C.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name James Ballard.
13. Birthplace Wilmington, N. C.

MOTHER 14. Maiden Name Susan Hooper.
15. Birthplace Wilmington, N. C.

16 (a) Informant Damon Green.
(b) Address 919 W. Lexington St.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 4-10-1947 (month) (day) (year)
(c) Cemetery or crematory
Location Wilmington, N. C.

18 (a) Funeral director Mrs. Kate R. Williams
(b) Address 322 N. Schroeder St.

19 (c) APR 8 1947 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/6 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-1 1947 to 4-6-47, and that I last saw her alive on 4-5- 1947

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Arteriosclerosis	
Obesity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Atwell Jones M. D.
Address 553 Dolphin St. Date signed 4-2-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50167 490 BALTIMORE CITY HEALTH DEPARTMENT 108 Registered No. G50167

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1119 Madison ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Madden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years 60 | Months — | Days — | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name ?
13. Birthplace ?

MOTHER 14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-9-47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem.
Location Baltimore City

18 (a) Funeral director Mrs Frances L Hemsley
(b) Address 578 N Bridle St.

19 APR 8 1947 (Date rec'd by Registrar) (b) Signature Mrs Frances L Hemsley

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-6-47 at 8:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-6-1947 to 4-6-1947 and that I last saw alive on 4-6-1947

Immediate cause of death	Duration
Lobar pneumonia	?
Left Upper Lobe.	
Due to	
Due to	
Other Conditions Arteriosclerotic heart disease (Include pregnancy within 3 months of death)	?

Date of operation
Major findings of operation:
of autopsy: As Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene Meyer M.D.
Address Johns Hopkins Date signed 4/8/47

For Bert G. Hefferly, Howard J. Mercer, M.D. 7/1/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50168 341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G50168

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 634 W. Lafayette Ave
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 634 W. Lafayette Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucian Dixon

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years	Months	Days	If less than one day
73			hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Charles Dixon
13. Birthplace Va.

MOTHER
14. Maiden Name Lizzie ?
15. Birthplace Va.

16 (a) Informant Mrs. Mary Jones
(b) Address 634 W. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-9-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) APR 8 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION P

20. DATE OF DEATH April 5, 1947, at 12:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1 1947 to 4/5 1947.
and that I last saw alive on 19
Immediate cause of death Cerebral Hemorrhage — Duration 4d
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. Williams M.D.
Address 1719 Eutaw Pl. Date signed 4/8/47

VS 150

G50169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

592 / 1318

Registered No. G50169

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1417 E. Eager St.
(c) Hospital or institution: D

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1417 E. Eager St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maria Wiggins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife John Wiggins
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 26, 1881

8. AGE: Years	Months	Days	If less than one day
65	5	10	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Johnson
13. Birthplace Va.

MOTHER
14. Maiden Name Pattie ?
15. Birthplace Va.

16 (a) Informant John Wiggins
(b) Address 1417 E Eager St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 8/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location Q. G. County Dept.

18 (a) Funeral director Mrs. Pitt & Ellwood Dept.
(b) Address 1129 N. Carlin St.

19 (a) APR 8 1947 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1947, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946 to 4-5 1947, and that I last saw h.... alive on 4/4 1947.

Immediate cause of death	Duration
Chronic Myocarditis	3 years
Due to	
Due to	
Other Conditions Chronic Nephritis	3 years?

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Calvin B. Le Crupte M. D.
Address 1113 N Carlin St Date signed 4/5/47

VS 150

G50170

422.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G50170
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 36-S. Catherine St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 36-S. Catherine St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julius A. Ebenhack.

3 (b) If veteran, name war: World War I.

3 (c) Social Security Account No. 212-05-8274

4. Sex: Male | 5. Color or race: White. | 6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Ellen A. Ebenhack.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 13-1891.

8. AGE: Years 55 | Months 3 | Days 23 24 | If less than one day hr. min.

9. Birthplace Baltimore - Md.
(Town, county, or state)

10. Usual Occupation Shipping Clerk.

11. Industry or business American Stay Bakery.

FATHER
12. Name Christian A. Ebenhack.
13. Birthplace Germany.

MOTHER
14. Maiden Name Ellen Hoffmann.
15. Birthplace Penna.

16 (a) Informant Mrs. Ellen A. Ebenhack.
(b) Address 36-S. Catherine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 10-47. (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore - Md.

18 (a) Funeral director Charles J. Sefusal.
(b) Address 3512 Frederick Ave.
Huntington Williams, Mgr.

APR 8 1947
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April, 6th. 1947, at 6.30 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1946 to 6 April 1947.
and that I last saw him alive on 6 April 1947.

Immediate cause of death Coronary Occlusion — Duration 4 hrs

Due to Hypertensive Cardio-Vascular Disease

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. H. Bayless
Address 1600 Wilkens Ave. Date signed April 9th 1947

VS 150

C-50171

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C-50171

CWK-109525 152 46E

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2508 Madison Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cora Belle Gardner

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife Phillip (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15-1864

8. AGE: Years	Months	Days	If less than one day
83	0	21	hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Dorsey Williams
13. Birthplace Virginia

MOTHER
14. Maiden Name Cora ?
15. Birthplace Virginia

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 11, 1947 (month) (day) (year)
(c) Cemetery or crematory Richmond Virginia
Location Henrico County

18 (a) Funeral director Joseph A. Seisly
(b) Address 66 West Base Street

19 (a) (b) Huntington Williams, M.D.
(Date sent to registrar) (Registrar)

APR 8 1947

MEDICAL CERTIFICATION P

20. DATE OF DEATH April 6 1947, at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 29 1947 to April 6 1947, and that I last saw her alive on April 6 1947.

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to	
Due to Bronchopneumonia	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Cerebral hemorrhage Bronchopneumonia
of autopsy: Arteriosclerosis of Coronaries

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Boyle Waldron M. D.
Address B.C.H. Date signed 4-7-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50172 875 E 982

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 167

Registered No. G50172

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1327 Smithson Street
(If rural give location)
(e) Citizen of foreign country? / (Yes or No)
If yes, name country

3 (a) FULL NAME LOUIS MURPHY

3 (b) If veteran, name war —

3 (c) Social Security Account No. ?

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Clara

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years 42 | Months 41 | Days | If less than one day hr. min.

9. Birthplace S. C.
(Town, county, and state)

10. Usual Occupation Butcher

11. Industry or business

FATHER
12. Name Murphy
13. Birthplace S. C.

MOTHER
14. Maiden Name
15. Birthplace S. C.

16 (a) Informant Clara Murphy
(b) Address 1327 Smithson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/8/47 (month) (day) (year)
(c) Cemetery or crematory Spartanburg
Location Spartanburg S C

18 (a) Funeral director Leg. D. Kelson
(b) Address 1203 Freedman Pl

19 (a) APR 8 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5, 1947, at 5:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab wound of right chest

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was ~~primary~~ ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-5-47 at 5:15 P. M.
(b) Where did injury occur? (Found) Mosher St & Arlington Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Sharp instrument

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 4-7-47

VS 181

G50473 ~~Dead~~ BCH D 77349 — BALTIMORE CITY HEALTH DEPARTMENT — G50473

CERTIFICATE OF DEATH 159

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1540 N. Fulton Avenue
(c) Hospital or institution: 776
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15'
(e) Length of stay in Baltimore (yrs., mos., or days) 4 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 1540 N. Fulton Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME INFANT Bell (Twin)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3 31 47

8. AGE: Years	Months	Days	If less than one day
			4 hr.s min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John H. Bell
13. Birthplace La.

MOTHER
14. Maiden Name Linnie Ellis
15. Birthplace N.C.

16 (a) Informant John H. Bell
(b) Address 1540 N. Fulton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/8/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Mrs. L. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) APR 8 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31, 1947, at M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil S. Rogers M.D. (Medical Examiner.)
Date signed

G50174

BALTIMORE CITY HEALTH DEPARTMENT

BC# 877348 776

CERTIFICATE OF DEATH 159

G50174

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1540 N. Fulton Avenue
(c) Hospital or institution:

15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1540 N. Fulton Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME INFANT Bell (Twin)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/31/47

8. AGE: Years	Months	Days	If less than one day
			4 hr. S. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER FATHER

12. Name John H. Bell
13. Birthplace La.

14. Maiden Name Linnie Ellis
15. Birthplace N.C.

16 (a) Informant John H. Bell
(b) Address 1540 N. Fulton Avenue

17 (a) Burial (b) Date thereof 4/8/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. D. Kelson
(b) Address 1303 Presstman St

19 (a) APR 8 1947 Huntington Williams
(Date received by Registrar) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31, 1947, at M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Prematurity

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D.
Medical Examiner.
Date signed

X

G50175

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

705.1 153

G50175 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1364 N. Stricker
(c) Hospital or institution:
15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Violet Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife S.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1911

8. AGE: Years	Months	Days	If less than one day
36 35			hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Chas. E. Johnson
13. Birthplace Va

MOTHER
14. Maiden Name Rebecca Dudley
15. Birthplace Va

16 (a) Informant Bernice Howard
(b) Address 1364 Stricker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/8/47 (month) (day) (year)
(c) Cemetery or crematory Lee Hall
Location Lee Hall, Va

18 (a) Funeral director Geo. H. Kelso
(b) Address 1303 Presstman St

19 (a) APR 8 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/5/47 19..., at 5:55 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pemphigus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John L. Davis M.D. Medical Examiner.
Date signed 4/6/47

X

G50176 002

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

G50476 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) ALA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1135 Ellamont Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RAYFIELD WILSON

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife Elsie Wilson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1892

8. AGE: Years	Months	Days	If less than one day
54	10	18	hr. min.

9. Birthplace Baltimore - Md (Town, county, and state)
10. Usual Occupation Porter
11. Industry or business Florist

FATHER
12. Name Frank Wilson
13. Birthplace St Marys Co, Md

MOTHER
14. Maiden Name Rachel Emory
15. Birthplace Maryland

16 (a) Informant Mrs Annie Richardson
(b) Address 113 Brewer St

17 (a) V (Burial, cremation, or removal) (b) Date thereof 4-9-47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore, Md

18 (a) Funeral director Mrs Leo H Holland
(b) Address 1631 Druid Hill Ave

19 APR 9 1947 (Date rec'd by registrar) Huntington Williams, MD Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/5/47 19 , 8:50 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Pulmonary Hemorrhage

Due to Tuberculosis ?

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Evans M.D. Medical Examiner.
Date signed 4/6/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50177 571

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1190a

G50177

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Linden & Madison Sts

(c) Hospital or institution Maryland General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Anne Arundel

(c) City or town Glen Burnie ~ Rural

(If outside city or town limits, write RURAL and give town)

(d) Street No. Oakwood Glen Burnie

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Baby Peter Edwards Kairos, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S.

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan. 5, 1947

8. AGE: Years	Months	Days	If less than one day
0	3	3	..... hr. ..... min.

9. Birthplace Glen Burnie, Rural

(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER

12. Name Peter E Kairos, Sr.

13. Birthplace Baltimore, Md.

MOTHER

14. Maiden Name Delores E. Burgmeier

15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Ester L. Smith

(b) Address Oakwood rd. - Glen Burnie, Md.

17 (a) Burial (b) Date thereof

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Glen Haven

Location Glen Burnie

18 (a) Funeral director Thomas W. Singleton

(b) Address Glen Burnie, Md.

APR 8 1947 (b) Huntington Williams, M.D.

(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8th 1947 at 6:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/6/ 1947 to 4/8/ 1947, and that I last saw h[im] alive on 4/7/ 1947

Immediate cause of death	Duration
Respiratory failure	
Due to Cardiac & dehydration	2 days.
Due to Diarrhea	
Other Conditions Terminal pneumonia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature C. E. Gonzalez

Address Maryland G. Hosp. Date signed 4/8/47

X

G50478 JL - 79935 360.0 87c G50178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
4 - 1- 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 627 S. Bond St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stanley Pocziak (Posiad)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1881

8. AGE: Years	Months	Days	If less than one day
66	3	4	hr. min.

9. Birthplace Poland
(Town, county, and state)
10. Usual Occupation Supported by D. P. W.
11. Industry or business

FATHER
12. Name Stanislaus Pocziak
13. Birthplace Poland

MOTHER
14. Maiden Name Anna Poplawski
15. Birthplace Poland

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof April 9/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore

18 (a) Funeral director Fred W. Ozarowski
(b) Address 1930 Eastern Ave.

19 (a) APR 8 1947 (Date rec'd by Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5, 1947, at 11:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 19 1943, to April 5 1947, and that I last saw him alive on April 5 1947.

Immediate cause of death	Duration
Respiratory Failure	1 day
Due to Parkinsonism, Arteriosclerotic	4 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.
Address Baltimore City Hosp. Date signed 4-6-47

X

G50179 422.2 BALTIMORE CITY HEALTH DEPARTMENT G50179
CERTIFICATE OF DEATH 937
Registered No.

Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2311 Hamilton Avenue
(c) Hospital or institution:
D. O. A. Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2311 Hamilton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert C. Schell

3 (b) If veteran, name war: none
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife: Doris Schell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 23, 1912

8. AGE: Years	Months	Days	If less than one day
34	3	13	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business Bendix Corp.

FATHER
12. Name James Schell
13. Birthplace Va.

MOTHER
14. Maiden Name Ada Connelly
15. Birthplace Va,

16 (a) Informant Mrs. Doris Schell
(b) Address 2311 Hamilton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/9/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) APR 8 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1947, at 10 11 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Congestive Heart Failure

Due to Myocardial Degeneration

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Ryan M.D. Medical Examiner.
Date signed 4-7-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50180

341

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 83a

G50180
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3305 Walbrook Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3305 Walbrook Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY ELIZABETH (LILLIE) LEILICH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife George R. L. Leilich
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 7, 1861

8. AGE: Years	Months	Days	If less than one day
85	4	0	hr. min.

9. Birthplace Penna.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name ? Kintz
13. Birthplace Pa.

MOTHER
14. Maiden Name Margaret Gehr
15. Birthplace Pa.

16 (a) Informant Mr. Frank Leilich
(b) Address 3305 Walbrook Ave.

17 (a) Burial (b) Date thereof 4/9/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Frederick, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
Address Balto., Md.

19 (a) APR 1947 (b) Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 7th 1947, at 12 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1947 to Apr 7 1947, and that I last saw h[illegible] alive on Apr 7 1947

Immediate cause of death	Duration
Cerebral Hemorrhage	8 days
and paralysis	
Due to advanced arteriosclerosis	7
Due to	
Other Conditions Hypertension	5 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Harold S Leitch M.D.
Address 2220 Garrison Blvd Date signed 4/8/47

G50181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

491 107

G50181 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2610 Lauretta Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 39 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2610 Lauretta Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BETTY F. DISE

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Rev. John T. Dise
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1874

8. AGE: Years	Months	Days	If less than one day
72	2 3	10	hr. min.

9. Birthplace Tangier, Va.
(Town, county, and state)

10. Usual Occupation -
11. Industry or business

FATHER
12. Name Richard A. Spence
13. Birthplace Va

MOTHER
14. Maiden Name Adeline Dise
15. Birthplace Tangier, Va

16 (a) Informant Mr. Calvin Dise
(b) Address 2610 Lauretta Ave.

17 (a) Burial (b) Date thereof 4/9/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 1947 (b) [illegible] Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-17-46 19 to April 6 1947 and that I last saw h[illegible] alive on 4-1-47 19

Immediate cause of death	Duration
Uremia and Bronchopneumonia	1 wk
Due to Senility & arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry S. Hunter M.D.
Address 2202 Edmondson Date signed 4-7-47

G50182

341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G50182

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 939 Sharp St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 939 Sharp St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eva Jackson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15, 1894

8. AGE: Years 52 | Months 6 | Days 20 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Davy Evans
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Nellie Glossary
(b) Address 937 Sharp St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 4-9-47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto Md

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 1082 Montgomery St

(c) Date received by registrar APR 8 1947 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/5/47 19 , at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/3/ 1947 to 4/5/ 1947.
and that I last saw h alive on 4/4/ 1947

Immediate cause of death Apoplexy — Duration 5 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J B Hamilton
Address 456 W. Biddle St Date signed 4/8/47

VS 150

G50483 BCH # 61334

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 6

G50183 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 062.0

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Univ Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balt. Md. (If outside city or town limits, write RURAL and give town)

(d) Street No. 629 S. Paca St. (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME Eric Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	B	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/6/46

8. AGE: Years	Months	Days	If less than one day
0	4	29	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Louis Johnson

13. Birthplace Md.

MOTHER 14. Maiden Name Elizabeth Troy

15. Birthplace Md.

16 (a) Informant Elizabeth Johnson

(b) Address 629 S Paca Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/8/47 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location A.R.C. Md

18 (a) Funeral director Daniel L Brown Jr

(b) Address 1018 W Montgomery St

19 (a) (Date rec'd) 1947 (b) (Registrar) Registrar

APR 8 1947 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/5 1947 at 8 25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/31 1947 to 4/5 1947

and that I last saw h(IM) alive on 4/5 1947

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Hemophilus Influenza Meningitis & Endocarditis	
Due to	
Other Conditions Bilat. Otitis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Meningitis; Bilat Otitis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Evan R. Jennings M.D.

Address Univ Hosp. Date signed 4/5/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50184 C.M. 109584 8687 044.4 27a

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G50184

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) 2½ Months

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1313 Bunsen Way Z24 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Beal Berryman

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 21- 1947

8. AGE: Years | Months 2 | Days 16 17 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Fountain Beal
13. Birthplace Md.

MOTHER 14. Maiden Name Blanch Beal Phelps
15. Birthplace Balto. Md.

16 (a) Informant Records Balto. city Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/8/47. (month) (day) (year)
(c) Cemetery or crematory Westen
Location E Monument Ave

18 (a) Funeral director Lilly & Gilbert
(b) Address 402 E. Fayette St

19 4/8 1947 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1947, at 8.40a M

21. I certify that death occurred on the date above stated; that I attended deceased from April 6 1947 to April 7 1947 and that I last saw h im alive on April 7 1947.

	Duration
Immediate cause of death Shock	1 day
Due to Dehydration	3 days
Carcinoma	
Due to Bacteremia dysentery	5 days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wilson E. Hughes M.D.
Address Balto City Hosp Date signed Apr. 7, '47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50185 341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G50185

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 146 S. Bouldin Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 78 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 146 S. Bouldin Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY ELIZABETH DISNEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOW

6 (b) Name of husband or wife John W. Disney, Sr
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 26, 1859

8. AGE: Years	Months	Days	If less than one day
87	6	12	hr. min.

9. Birthplace VIRGINIA (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ? Warwick
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Carroll
15. Birthplace New York

16 (a) Informant Miss Florence Disney
(b) Address 146 S. Bouldin Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/11/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) APR 8 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 APRIL 1947, at 7:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 29 JAN. 1947 to 7 APRIL 1947, and that I last saw h.sr alive on 7 APRIL 1947.

Immediate cause of death	Duration
CEREBRAL HEMORRHAGE	3 hrs
ARTERIOSCLEROSIS GENERALIZED	20 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
Signature Benjamin Hilfinger M. D.
Address 121 S. HIGHLAND AVE. Date signed 7 APRIL 47

G50186

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

442.1 / 131a

Registered No. G50186

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1823 North Caroline St.
(c) Hospital or institution: 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1823 North Caroline St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Shagogue

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. NONE

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife: Frederick Shagogue
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 2, 1866

8. AGE: Years 80 | Months 5 | Days 4 | If less than one day ..... hr. ..... min.

9. Birthplace: Baltimore Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Thomas Conner
13. Birthplace: Baltimore Md.

MOTHER
14. Maiden Name: Caroline Stout
15. Birthplace: Baltimore Md.

16 (a) Informant: Mrs. Bessie Walker
(b) Address: 1823 N. Caroline St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 9, 1947 (month) (day) (year)
(c) Cemetery or crematory: Greenmount Cem.
Location: Baltimore Md.

18 (a) Funeral director: H. Sander & Sons Inc.
(b) Address: North Ave & Broadway

19 (a) APR 8 1947 (Date rec'd by registrar) Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8, 1947, at 8:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1947 to April 6 1947 and that I last saw her alive on April 6 1947

Immediate cause of death: Coronary thrombosis — Duration: Sudden

Due to: Asteno-Sclerotic Cardio-Vascular renal disease

Due to:

Other Conditions: Ascites

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Geo W Baumgardner M. D.
Address: Balto 6 Md Date signed 4-7-47

X

G50187
CWK-109519 072

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G50187

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 22- 9- 19-

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5919 Greenhill Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy (Tumlehn) Rumlehn

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-14-0017

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17-1924

8. AGE: Years	Months	Days	If less than one day
22	9	19	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles H. (Tumlehn) Rumlehn
13. Birthplace Maryland

MOTHER
14. Maiden Name Roberta Kerner
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 10 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location

18 (a) Funeral director Hauck
(b) Address 530 Reisterstown Rd.

19 (Date rec'd by registrar) APR 8 1947 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1947, at 8:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 29 1947, to April 6 1947, and that I last saw h her alive on April 6 1947.

Immediate cause of death	Duration
Pulmonary Tuberculosis, Far advanced	8 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: not obtained

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Helwig M. D.
Address Balt. City Hosp. Date signed 4/7/47.

X

G50188

O'Loughlin

BALTIMORE CITY HEALTH DEPARTMENT

420.1 CERTIFICATE OF DEATH V 94a

Registered No. G50188

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 5404 Garland Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD O'LOUGHLIN

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Marguret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 25 1887?

8. AGE: Years	Months	Days	If less than one day
60	1	9	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation American Oil Co

11. Industry or business

FATHER — 12. Name William O'Loughlin

13. Birthplace

MOTHER — 14. Maiden Name Catherine —

15. Birthplace

16 (a) Informant Edwin W. O'Loughlin

(b) Address 5404 Garland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 9, 1947 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location

18 (a) Funeral director Burk & Sheppard

(b) Address 53 S Paca St Rd

19 (a) APR 8 1947 (Date rec'd by registrar) Huntington Williams, Md

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6, 1947, at 9:35 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Emil H Beyer M.D. (Medical Examiner.)

Date signed

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50189 002

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G50189

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hospital
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 115 W. Mulberry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Schultz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. ?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years 75 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof 4 8 47 (month) (day) (year)

(c) Cemetery or crematory Sacred Heart

Location Herman Hill Rd

18 (a) Funeral director J. J. Tafft & Son

(b) Address 1316 Light St

19 (a) APR 8 1947 (Date received by registrar) Huntington Williamson, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1947, at 6:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis.
Extensive scarring of heart.
Scarring of kidneys.
Marked arteriosclerosis.
Pulmonary tuberculosis.
Chronic passive congestion liver
Scarring of pancreas

Other Conditions Malunited fracture of neck of rt. fe

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ..... at ..... M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature George C. Merrill M.D. Medical Examiner.

Date signed 3/31/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C50190 427.2 937 Registered No. C50190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution: Elmhurst Nursing Home 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) 7
(d) Street No. 3205 Belmont Ave., (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ludwig Hartig

3 (b) If veteran, name war ----
3 (c) Social Security Account No. ----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband~~ or wife Bettie Hartig
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 12, 1858

8. AGE: Years	Months	Days	If less than one day
88	3	26	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired Grocer
11. Industry or business

FATHER
12. Name
13. Birthplace Germany

MOTHER
14. Maiden Name Karoline Eberts
15. Birthplace Germany

16 (a) Informant Mrs. Bettie Hartig
(b) Address 3205 Belmont Ave.,

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 4-10-47 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore, Md.

18 (a) Funeral director S. Howard Strong
(b) Address 3207W. North Ave.

APR 8 1947 (Date rec'd by Registrar) (by) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7, 1947, at 4.45 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 19 1947 to April 7, 1947 and that I last saw him alive on April 1, 1947

Immediate cause of death	Duration
Congestive heart failure	2 days
Due to Chronic suppurative Degeneration &	
Due to arteriosclerosis	9
Other Conditions Urinary incontinence from prostatic hypertrophy (Include pregnancy within 3 months of death)	7

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Maurice E. Shadow M. D.
Address 3300 N. Northern Date signed 4/8/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50191 443.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G50191 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St
(c) Hospital or institution: South Balto Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna (b) County
(c) City or town Drexel Hill
(If outside city or town limits, write RURAL and give town)
(d) Street No. 721 Morgan Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elsie Isenthal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Leo Isenthal
6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) 9/15/1885

8. AGE: Years 61 | Months 6 | Days 23 | If less than one day ..... hr. ..... min.

9. Birthplace Columbia, Pa
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Joseph Baker
13. Birthplace Pa

MOTHER 14. Maiden Name Jennie McCardy
15. Birthplace Pa

16 (a) Informant husband
(b) Address 721 Morgan ave Drexel Hill Pa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-12-47 (month) (day) (year)
(c) Cemetery or crematory Westminster Cem
Location Philadelphia Pa

18 (a) Funeral director Leo L. Berger Jr
(b) 1512 Hollins St

19 (a) 1947 (Date rec'd by reg.) Wilmington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1947 at 1 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 5 1947 to April 8 1947 and that I last saw her alive on April 8 1947.

Immediate cause of death: Subarachnoid hemorrhage — Duration: ....

Due to: Hypertensive cardiovascular disease — Duration: 3 years

Due to: ....

Other Conditions: ....

(Include pregnancy within 3 months of death)

Date of operation: ....

Major findings of operation: ....

of autopsy: ....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: ....
(b) Date of occurrence: .... at .... M
(c) Where did injury occur? .... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? .... While at work? .... (Specify type of place)
(e) Means of injury: ....

23. Signature: Howard C. Hillman M. D.
Address 213 Light St Date signed April 8, 47

VS 150

G50192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

422.1

G50192

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2228 N. Calvert St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 y 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2228 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE G. FURLONG

3 (b) If veteran, name war ---

3 (c) Social Security Account No. ---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Phillip Furlong
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years	Months	Days	If less than one day
82			hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Annie G. Coffey
15. Birthplace Sykesville, Md.

16 (a) Informant Mr. Phillip Furlong
(b) Address 2228 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/9/47 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Govans

18 (a) Funeral director WIEDEFELD AND SON
(b) Address GREENMOUNT AVE & 22ND

19 1947 Date rec'd by registrar Huntington Williams M.D. Registrar

APR 8

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5th, 1947 at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 1 1947 to Apr. 5 1947 and that I last saw h[illegible] alive on Apr. 3 1947.

Immediate cause of death Chr. Myocarditis — Duration Indefinite

Due to

Due to

Other Conditions Generalized Arteriosclerosis — Duration Indefinite
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nathaniel M. Beck M. D.
Address 1606 E. 23rd St Date signed Apr. 7-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50193 491

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓107

G50193 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Montgomery
(c) City or town Burtonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Linda Sharon Murphy
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 30, 1946 [illegible]

8. AGE: Years | Months 3 | Days 8 | If less than one day ..... hr. ..... min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Mr Maurice Murphy
13. Birthplace Md

MOTHER 14. Maiden Name Thelma Weakley
15. Birthplace Md

16 (a) Informant Maurice J Murphy
(b) Address Burtonsville, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-11-47 (month) (day) (year)
(c) Cemetery or crematory Burtonsville
Location Burtonsville Montg Co Md

18 (a) Funeral director W E Dunkhurst
(b) Address 8434 Ga Ave S.S. Md

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

APR 8 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1947, at 2:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7 April 1947, to 7 April 1947, and that I last saw her alive on 7 April 1947.

Immediate cause of death: Pneumonia — Duration: over

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sydney A. Gerrer M. D.
Address Sinai Hospital, Baltimore Date signed 8 April 1947

X

G50194 A62.0 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH ✓6 G50194 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4½ hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 4½ hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County? Baltimore
(c) City or town White Hall (rural) (If outside city or town limits, write RURAL and give town)
(d) Street No. White Hall (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond Russell Miller ✓

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 28, 1945

8. AGE: Years 1 | Months 6 | Days 10 | If less than one day hr. min.

9. Birthplace ? Whitehall, Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Edward Miller
13. Birthplace Maryland

MOTHER
14. Maiden Name Delia Hare
15. Birthplace Maryland

16 (a) Informant Hospital Records.
(b) Address Union Memorial, Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-10-47 (month) (day) (year)
(c) Cemetery or crematory Asbury M.E.
Location Cockeysville, Md.

18 (a) Funeral director Layton M. Brooks
(b) Address Sparks, Md.

19 (Date received by registrar) APR 8 1947 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1947, at 3:48 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 8 1947 to April 8 1947. and that I last saw him alive on April 8 1947.

	Duration
Immediate cause of death: Meningococcemia	1½ days
Due to: Meningococcus meningitis	1½ days
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ernest V. deMoss M.D. M. D.
Address Union Memorial Hosp. Date signed Apr. 8 '47

VS 150

G50495 153 BALTIMORE CITY HEALTH DEPARTMENT 467 G50195

CERTIFICATE OF DEATH

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians; please write the correct age is especially important. the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution: Univ Mem Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State PENNA. (b) County
(c) City or town NOTTINGHAM PENNA (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME LAURA S. McALLISTER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife WINFIELD S. McALLISTER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG 2, 1899

8. AGE: Years 47 | Months 8 | Days 7 | If less than one day hr. min.

9. Birthplace PENNA (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name CHRISTOPHER HERSHOUR
13. Birthplace PENNA

MOTHER
14. Maiden Name RACHEL JONES
15. Birthplace PENNA.

16 (a) Informant Winfield S. McAlister
(b) Address Nottingham R.D.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 13 (month) (day) (year)
(c) Cemetery or crematory Little Britain
Location Lancaster, Pennsa.

18 (a) Funeral director J. E. Tagany
(b) Address Nottingham Penna.

APR 9 1947 (a) Date received by registrar (b) Huntingdon Williamsport Pa

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 9 1947, at 3:20A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 25 1947 to April 9 1947, and that I last saw h.er alive on April 9 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Atelectasis	1 day
Due to Post operative complications	
Other Conditions Carcinoma rectum → Arteriosclerotic Heart disease → (Include pregnancy within 3 months of death)	2 years → 5 years

Date of operation MARCH 24, 1947
Major findings of operation: Carcinoma rectum
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph C. Pugh M. D.
Address Univ Mem Hosp Date signed April 9, 1947

X

G50496

BALTIMORE CITY HEALTH DEPARTMENT

422.2 CERTIFICATE OF DEATH 1937

G50496 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fulton + Madison Ave
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 653 Washington Boulevard (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara R. Pauley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) ~~Single, married~~, widowed, or ~~divorced~~ Widowed

6 (b) Name of husband ~~or wife~~ Charles Pauley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 7th 1885

8. AGE: Years 61 | Months 5 | Days 0 | If less than one day hr. min.

9. Birthplace Cerro Va. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business At Home

FATHER
12. Name John Lambert
13. Birthplace Cerro Va

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Red Cross
(b) Address

17 (a) Removal (~~Burial, cremation, or~~ removal) (b) Date thereof 4/9/47 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Tip Top Va
Location
William Cook Inc.
18 (a) Funeral director
(b) Address 127 St. Paul St.

APR 9 1947 (Date rec'd by Registrar) (b) Signature for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7th 1947, at 2:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/29/1947, to 4/7/1947, and that I last saw her alive on 4/7/1947.

Immediate cause of death Cardiac failure — Duration

Due to A.C.S. Disease — 9 days

Due to Uremia Chronic Nephritis and Toxemia

Other Conditions tion of C.C.D.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Pancreas alone + hepatitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. E. Gonzalez

Address Maryland 2 Days Date signed 4/7/47

X

G50197

341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

843a

G50197

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1033 Argyle Ave
(c) Hospital or institution: D.O.A.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1033 Argyle Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Wilkens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Minnie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1911

8. AGE: Years: 36 | Months | Days | If less than one day: hr. min.

9. Birthplace: Garrison, S. C.
(Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: South Carolina

MOTHER
14. Maiden Name: Unknown
15. Birthplace: South Carolina

16 (a) Informant: Minnie Wilkens
(b) Address: 1370 N. Calhoun St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/9/47 (month) (day) (year)
(c) Cemetery or crematory: Mt. Calvary
Location: Cedar Hill, Md.

18 (a) Funeral director: A. Halstead
(b) Address: 918 Druid Hill Ave.

APR 9 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/6 1947, at 5:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: C. J. Lubinski M.D.
Medical Examiner.
Date signed 4/6/47

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50198 260 BALTIMORE CITY HEALTH DEPARTMENT 61 G50198 Registered No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 514 Division St
(c) Hospital or institution: Provident 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 51 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2513 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Josephine Gray Brinkley.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe	N	Widowed

6 (b) Name of husband or wife John Brinkley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/6/95

8. AGE: Years	Months	Days	If less than one day
51	5	29	hr. min.

9. Birthplace Charles County, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John R. Gray
13. Birthplace Charles Co Md

MOTHER
14. Maiden Name Maria Butler
15. Birthplace Charles Co Md

16 (a) Informant Lucy Gray
(b) Address 2513 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 9, 1947 (month) (day) (year)
(c) Cemetery or crematory St Peters Cemetery
Location

18 (a) Funeral director Mrs. Katie R Williams
(b) Address 3221 Schroeder St

APR 9 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/5 1947 at 4:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/30 1947 to 4/5 1947, and that I last saw h.e alive on 4/5 1947.

Immediate cause of death	Duration
Uremia	
Due to Renal Insufficiency	6 days
Due to	
Other Conditions Diabetic Coma Complicating Dia. mellitus	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H H Barfield M.D.
Address Rowland Bldg Date signed 4/8/47

G50199 420.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G50199

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not abbreviate. Do not use ditto marks. If unknown, write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3100 Batavia
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 77
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3100 Batavia Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie E Hall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 28 1872

8. AGE: Years	Months	Days	If less than one day
75	2	29	hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER 12. Name Karl G Hall

13. Birthplace Ger

MOTHER 14. Maiden Name Marie Schroeder

15. Birthplace Ger

16 (a) Informant Miss Matilda Hall

(b) Address 3100 Batavia Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 9 1947 (month) (day) (year)

(c) Cemetery or crematory Balto Cem

Location Balto

18 (a) Funeral director Mitchell Funeral Home

(b) Address 2008 Orleans St

19 (a) Date received APR 9 1947 (b) Registrar [illegible] Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1947, at 2P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 5 1947 to April 6 1947 and that I last saw her alive on April 6 1947

Immediate cause of death	Duration
Coronary Thrombosis Followed by Myocardiac Failure	
Due to Arteriosclerosis generalized	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J. Brennan M. D.

Address 5217 Harford Rd Date signed 9-7-47

X

G-50500

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52a

Registered No. G-50500

City No. 108540 190

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Spring Grove Hospitals (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Malinowski, Stanley

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	? SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June -22-1886

8. AGE: Years	Months	Days	If less than one day
60	9	15	hr. min.

9. Birthplace ? POLAND
(Town, county, and state)

10. Usual Occupation

11. Industry or business CORE MAKER

FATHER
12. Name ? UNKNOWN
13. Birthplace ? "

MOTHER
14. Maiden Name ? UNKNOWN
15. Birthplace ? "

16 (a) Informant Records Balto City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) BURIAL (b) Date thereof 4 10 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory HOLY CROSS
Location RITCHIE HGWY

18 (a) Funeral director JOHN F. DENNY, INC.
(b) Address 715 LIGHT ST.

19 Date filed APR 9 1947 (b) Registrar [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1947, at 6.00A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 18 1947 to April 7 1947 and that I last saw h im alive on April 7 1947

Immediate cause of death Carcinoma - Right Kidney — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maurice M. Levy, M.D.
M. D.
Address Baltimore City Hosp. Date signed 4-7-47

G50501

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G50501 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH

(a) Baltimore City, Md.

(b) Street address 918 Baylis Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2

(e) Length of stay in Baltimore (yrs., mos., or days) 80 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 918 S. Baylis Street (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Siedlecki

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Anna Siedlecki

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sep 1867

8. AGE: Years	Months	Days	If less than one day
79 80	7		hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Peter Siedlecki

13. Birthplace Poland

MOTHER 14. Maiden Name unknown

15. Birthplace Poland

16 (a) Informant Albert Siedlecki

(b) Address 918 S. Baylis Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-10-47 (month) (day) (year)

(c) Cemetery or crematory St Stanislaus Cem

Location Baltimore City

18 (a) Funeral director John M. Welsh

(b) Address 404 S. Chester Street

APR 9 1947 (Date rec'd by local reg.) (b) Washington Blvd

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1947, at 9 45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1946 to April 7 1947 and that I last saw h[illegible] alive on April 7 1947

Immediate cause of death Chronic myocarditis. — Duration 2 yrs.

Due to —

Due to —

Other Conditions nephritis — Duration 1 yr.

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury —

23. Signature Frank A. Januszeski M. D.

Address 2479 Fait Date signed 4-8-47

FRANK A JANUSZESKI X

G50502

422.2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G50502

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 28 1/4 Brighton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1274 Battery Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sara Stricker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife George J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 15, 1874

8. AGE: Years 73 | Months 0 | Days 22 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation At Home

11. Industry or Business

MOTHER / FATHER

12. Name James McKenna

13. Birthplace Md

MOTHER

14. Maiden Name Sara Higgins

15 Birthplace Md

16 (a) Informant Mrs Joseph Dredeck

(b) Address 2814 Brighton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 10 '47 (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location Brooklyn

18 (a) Funeral director J. Kemp

(b) Address 5365 Harford Rd

19 (a) [illegible] rec'd (Registrar) (b) [illegible]

APR 9 1947

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-6 1947, at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-1- 1945 to 4-6 1947.
and that I last saw h[illegible] alive on 4-5 1947.

	Duration
Immediate cause of death Chronic Myocardial Degeneration	2 yr.
Due to Arteriosclerosis	3 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. M. Gallod M. D.
Address 207 Fort Ave. Date signed 4-6-47

G50503

261

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G50503
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 67d
(e) Length of stay in Baltimore (yrs., mos., or days) 83yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3401 Hamilton Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Emma S. Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
fem.	Wh.	M

6 (b) Name of husband or wife Charles F. Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 25, 1864

8. AGE: Years	Months	Days	If less than one day
82	6	13	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housf.
11. Industry or business

FATHER
12. Name Frederick Vinup
13. Birthplace Germany.

MOTHER
14. Maiden Name Lena ?
15. Birthplace Germany.

16 (a) Informant Hosp. Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/12/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave
18 (a) Funeral director Leonard J. Burke
(b) Address 5305 Harford Road
19 (a) [illegible] by Huntington Williams, M.D.

APR 9 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-8-47 19 , at 5:00 p M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-30 1947 to 4-8 1947 and that I last saw h[illegible] alive on 4-8 1947

Immediate cause of death	Duration
resp. failure	
Due to arterio sclerotic cardio vascular disease	
Due to Diabetes mellitus	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature James J. Gerlach M. D.
Address Mercy Hosp Date signed 4-8-47

C50501 443.1

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. C50501

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 441 Cummings Ct
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 441 Cummings Ct (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude Boyce

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: C
6 (a) Single, married, widowed, or divorced: M
6 (b) Name of husband or wife: Randolph
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1909

8. AGE: Years: 38 37 | Months: | Days: | If less than one day: hr. min.

9. Birthplace: md (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:

FATHER
12. Name: Arthur Beats
13. Birthplace: md

MOTHER
14. Maiden Name: Alveita Brown
15. Birthplace: Va.

16 (a) Informant: Randolph Boyce
(b) Address: 441 Cummings Ct

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/9/47 (month) (day) (year)
(c) Cemetery or crematory: Mt Auburn
Location: Md

18 (a) Funeral director: Meg. H. Kelson
(b) Address: 1303 Pressman St
(c) Date received by local registrar: APR 9 1947 Huntington-Williams, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/6/1947. 6:36 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/4/1947 to 4/6/1947 and that I last saw h[illegible] alive on 4/2/1947.

Immediate cause of death: Cardiac Hypertrophy & Hypertension — Duration: 6 Days
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: B. Z. Hatcher
Address: [illegible] Date signed: 4/8/47

G50505 442-1

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1312

Registered No. G50505

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1369 Gilmor St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1369 Gilmor St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles H. Dunton
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. M
6 (b) Name of husband or wife Clara
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1874
8. AGE: Years 73 | Months | Days | If less than one day hr. min.
9. Birthplace Virginia (town, county, and state)
10. Usual Occupation Laborer
11. Industry or business
FATHER 12. Name Jacob Dunton
13. Birthplace Va
MOTHER 14. Maiden Name Charlotte Reed
15. Birthplace Va.
16 (a) Informant Clara Dunton
(b) Address 1534 Lexington St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-10-47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md
18 (a) Funeral director George G. Kelson
(b) Address 1303 Pennsylvania Ave
Apr 9 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1947, at 7:30 M
21. I certify that death occurred on the date above stated; that I attended deceased from 4/4 1947, to 4-6 1947.
and that I last saw him alive on 4/4 1947.

Immediate cause of death	Duration
Cardio vascular Renal disease	
Due to pulmonary edema	6 Mos
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature R. L. JACKSON
Address Cor Walnut Date signed 4/8/47

VS 150

G50506 503 E813.0

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No. G50506

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 1315 Whatcoat St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ALONZO HURLEY ALONZO. HURLEY

3 (b) If veteran, name war ? | 3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/3/1919

8. AGE: Years	Months	Days	If less than one day
27	2	1	hr. min.

28

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business

FATHER
12. Name Ernest Hurley
13. Birthplace Md

MOTHER
14. Maiden Name Estella Hurley (Diaz)
15. Birthplace Md

16 (a) Informant Estella Hurley
(b) Address 1315 Whatcoat St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/10/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. D. Kelson
(b) Address 1303 Pressman St

19 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4, 1947 at 11:15 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions (Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-4-47 at 1220 P. M. 19/3
(b) Where did injury occur? Pratt St. 105' west of Carrie Street
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Auto. overturned after being hit striking tractor-trailer and then striking push-cart

23. Signature Earl Kleyer M.D. Medical Examiner.
Date signed 4-5-47

VS 151

G50507

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

442.1 / 131a

Registered No. G50507

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1416 W Lanvale St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1416 Lanvale St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bessie Hampton

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

4. Sex: F
5. Color or race: C
6 (a) Single, married, widowed, or divorced: W
6 (b) Name of husband or wife: Grant
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years 75 | Months 4 | Days | If less than one day ... hr. ... min.

9. Birthplace King & Queen Co, Va (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Unobtainable
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Pearl Watty
(b) Address 1416 Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/10/47 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Md

18 (a) Funeral director Geo. B. Kelson
(b) Address 1303 Eutaw St

19 APR 9 1947 (Date rec'd by local registrar) (b) Huntingtown, Williamsport, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/7 1947, at 3P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1 1947 to 4/7 1947 and that I last saw h[illegible] alive on 4/7 1947.

Immediate cause of death: Cardio-Renal — Duration: 7 Days

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature H. F. Hatcher
Address 1115 Eutaw Date signed 4/8/47

X

C50508

BALTIMORE CITY HEALTH DEPARTMENT

CWK-84066 023 **CERTIFICATE OF DEATH** 30E

Registered No. C50508

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5- 6- 5- 16
(e) Length of stay in Baltimore (yrs., mos., or days) 68- 9- 28-

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1007 W. Carrollton Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** William R. Shorts

3 (b) If veteran, name war X

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widowed

6 (b) Name of husband or wife Lavinia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6-1878

8. AGE: Years	Months	Days	If less than one day
68	9	28	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name William Shorts
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Hamilton
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/9/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N. Carrollton Ave

19 (a) 1947 (Registrar's number) Huntington Williams, M.D. by registrar Registrar

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH April 4 19 47, at 5:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 29 19 43, to Apr. 4 19 47, and that I last saw h. im alive on Apr. 4 19 47.

Immediate cause of death	Duration
Bronchopneumonia	7 days
Due to organism undetermined	
Due to	
Other Conditions Heart Disease due to Syphilis and Hypertension	4-5 years

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Lawrence Lee Jr. M. D.
Address Baltimore City Hosp. Date signed 4-5-47

107

B50509 592 BALTIMORE CITY HEALTH DEPARTMENT 131a Registered No. G50509

CERTIFICATE OF DEATH

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1707 N. Patterson Park Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1707 N. Patterson Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Salvatore Allisi

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 10th 1871

8. AGE: Years 75 | Months 4 | Days 27 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Salvatore Allisi
13. Birthplace Italy

MOTHER 14. Maiden Name Fannie Talbert
15. Birthplace England

16 (a) Informant Mrs Greenfield
(b) Address 1707 N. Patterson Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-10th 1947 (month) (day) (year)
(c) Cemetery or crematory St. Peters
Location Bentalou St

18 (a) Funeral director Leo G. Cook
(b) Address 1701-03 N. Patterson Park Ave

19 (a) (Date rec'd) (Registrar) Williamsport Md

APR 9 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-7th 1947, at 2.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1942 to April 7 1947 and that I last saw h[illegible] alive on April 7 1947.

Immediate cause of death	Duration
Chronic glomerulonephritis	4 years
Uremia	
Due to	
Due to	
Other Conditions	

Generalized arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Krenger M.D.
Address 1402 E. Lanvale Date signed 4-8-47

X

G50510

290.0

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 73a

G50510
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1417 E. Clement St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1417 E. Clement St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY MARKOWSKI (MARIE MARKOSKI)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Joseph MARKOWSKI
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 1875

8. AGE: Years	Months	Days	If less than one day
72	2		hr. min.

9. Birthplace Poland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph MARKOWSKI
13. Birthplace Poland

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace " "

16 (a) Informant FRANK J. MARKOWSKI
(b) Address 1417 E. Clement St.

17 (a) Burial (b) Date thereof 4/11/42
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem.
Location

18 (a) Funeral director Charles F. Peiffer
(b) Address 1501 E. Fort Ave

19 (a) APR 9 1942 (b) Huntington Williamson W.Va.
(Date rec'd by Registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1942 at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 27 1942 to April 7 1942, and that I last saw her alive on April 7 1942

Immediate cause of death Acute cardiac decomp. Duration 1 wk
Pernicious Anemia

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature B. F. Barranco
Address 436 B Fontaine Date signed 4/9/42

X

G50511 803 E865 BALTIMORE CITY HEALTH DEPARTMENT 176 G50511

CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1628 E. Clement St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bernard Grodzicki

3 (b) If veteran, name war: World War II
3 (c) Social Security Account No. 115-03-4939

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mary Grodzicki
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14, 1921

8. AGE: Years 25 | Months 9 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Stevedore
11. Industry or business

FATHER
12. Name John Grodzicki
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Sledge
15. Birthplace Baltimore

16 (a) Informant Mary Sledge
(b) Address 1628 E Clement St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/12/47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem.
Location Govanhill Rd.

18 (a) Funeral director Charles F. Hill
(b) Address 1501 E. Fortieth

APR 9 1947 (Date rec'd by Registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1947 at 5:00 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull

Due to

Other Conditions Subarachnoid and subdural hemorrhage
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-7-47 at 4:10 A.M.
(b) Where did injury occur? Pier #1 Balt. H. Penn. R.R.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial Place While at work? yes
(d) Means of injury Struck by boom

23. Signature [signature] M.D. Medical Examiner.
Date signed 4-8-47

G50512

BL# B65304 491

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G50512 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Cager & Hudelson
(c) Hospital or institution: Mt Balto Gen Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 5-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore 25 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1305 Harmonet Ct. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Horwath

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M.

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/18/46

8. AGE: Years | Months 3 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Andrew Horwath Jr.
13. Birthplace Upper Lehigh Penn.

MOTHER
14. Maiden Name Dorothy Smith
15. Birthplace Durham, England

16 (a) Informant Andrew Horwath Jr.
(b) Address 1305 Homeward

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4/9/47 (month) (day) (year)
(c) Cemetery or crematory St Peters & Pauls Cem
Location Freeland, Pa.

18 (a) Funeral director Charles F. Stell
(b) Address 1501 E. Fayette Ave.

APR 9 1947 (Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 April 1947, at 3:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7 April 1947, to 8 April 1947, and that I last saw h[illegible] alive on 8 April 1947

Immediate cause of death: Respiratory Failure — Duration

Due to: Bilateral Confluent Broncho Lobular Pneumonia

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lester G. Stall Jr. M. D.
Address Mt Balto Gen Date signed 4/8/47

VS 150

G50513 341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

Registered No. G50513

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2547 Madison Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2547 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert Parker Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife Jennie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 19, 1874

8. AGE: Years 72 | Months 4 | Days 18 | If less than one day hr. min.

9. Birthplace Chesterfield, Md.
(Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER 12. Name Herbert Parker
13. Birthplace Maryland

MOTHER 14. Maiden Name Elizabeth Bradford
15. Birthplace Maryland

16 (a) Informant Miss Georgianna Parker
(b) Address 2547 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 11, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location Baltimore Md.

18 (a) Funeral director Mrs. Geo. A. Holland
(b) Address 1631 Druid Hill Ave

19 (a) APR 9 1947 (Date received by registrar) (b) Arlington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-7-1947 at 4:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-1-1947 to 4-5-1947 and that I last saw h[illegible] alive on 4-5-1947.

Immediate cause of death Cerebral Apoplexy — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. N. Hofstetter

Address 1415 Park Date signed 4/8/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Exact age is especially important. Physicians: please write the causes of death clearly and legibly.

650514 490

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. 650514

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 644 Pitcher St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 644 Pitcher St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clara Dow (Hawkins) Hankins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Alfred L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22, 1865

8. AGE: Years 71 | Months 10 | Days 14 | If less than one day ... hr. ... min. 1875

9. Birthplace Harrington, Va (town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Nash
13. Birthplace Harrington, Va

MOTHER
14. Maiden Name Amanda Turner
15. Birthplace Loudon, Va

16 (a) Informant Mrs. Margaret Hankins
(b) Address 644 Pitcher St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 9, 1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Park
Location Balto. Co. Md.

18 (a) Funeral director Mrs. Geo. H. Holland
(b) Address 1631 Druid Hill Ave

19 (a) 1947 (Date received by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5th 1947 at 5 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 1/17 1947 to 4-5 1947 and that I last saw h alive on

Immediate cause of death
(a) Lobar Pneumonia
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. A. Hatcher M.D.
Address 1115 Linden Ave Date signed 4/8/47

V S 150

C50515

341

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

83a

Registered No. C50515

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 724 Mundow Rd, Guilford
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 724 Mundow Rd, Guilford (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Corinne Harris Mordecai

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband ~~ex-wife~~ Henry Mordecai

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1st 1856

8. AGE: Years 91 | Months 3 | Days 9 | If less than one day ____ hr. ____ min.

9. Birthplace New Orleans, La (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Moses Harris
13. Birthplace unknown

MOTHER
14. Maiden Name Cecile Marie Antoinette de Lamaletie
15. Birthplace Paris

16 (a) Informant Mattie C. Mordecai
(b) Address 177 E. 73rd. Street, New York City

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Apr 11 1947 (month) (day) (year)
(c) Cemetery or crematory Maple Grove
Location New Gardens Long Island N.Y.

18 (a) Funeral director Henry W. Jenkins Sons Co
(b) Address McCulloh & Orchard Sts.

19 (a) 1947 (Date rec'd by registrar) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9th 1947, at 1.30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1st 1947, to April 9 1947, and that I last saw her alive on April 9 1947.

Immediate cause of death: Myocardial Pneumonia, Senile Asthenia

Duration: 1 day, 1 week

Due to: Arterio-Sclerosis

Due to:

Other Conditions: 0

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: 0

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. L. Ghilard M. D.

Address 724 Mundow Rd Date signed April 9/47

G50516

410

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B

Registered No. G50516

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts.
(c) Hospital or institution: Mercy Hospital. 15-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3411 Piedmont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Alice Campbell

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	705-03-4389

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife –
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 16, 1879

8. AGE: Years	Months	Days	If less than one day
68	0	21	hr. min.

9. Birthplace Ill. (Carbondale) (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business B & O R R

FATHER
12. Name John G. Campbell
13. Birthplace Tenn.

MOTHER
14. Maiden Name Alice Beman
15. Birthplace Mt. Zion, Ga.

16 (a) Informant Miss Frances Campbell
(b) Address 3411 Piedmont Ave.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof April 10, 1947 (month) (day) (year)
(c) Cemetery or crematory Greenmount Crematory
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) D rec'd Apr 9 1947 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-7 1947, at 9.07 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-5-1947 to 4-7-1947 and that I last saw h.r alive on 4-7-1947

Immediate cause of death	Duration
Cardiac Failure	
Due to Rheumatic Cardio Vasc Disease	
Due to Cerebral Embolism	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles H. Hardbarger M. D.
Address Univ. Hosp. Date signed 4-7-47

X

G50517

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G50517

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2203 Baker (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANKLIN E. ROLLMAN

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Lillian R. Rollman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 31, 1882

8. AGE: Years	Months	Days	If less than one day
64	7	8	hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Piano Tuner

11. Industry or business: Self

FATHER
12. Name: Charles Rollman
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Emma Schmidt
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mrs. Lillian R. Rollman
(b) Address: 2203 Baker St.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 4/11/47 (month) (day) (year)
(c) Cemetery or crematory: Greenmount Crematory
Location: Baltimore, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Baltimore, Md.

19 (a) Date rec'd APR 9 1947 (b) Registered by

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/8/47 19..., at 2 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Vascular Disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D. Medical Examiner.
Date signed 4/9/47

X

G50518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92c

G50518 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2870 Woodbrook Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2862 Woodbrook Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AMELIA HILD

3 (b) If veteran, name war –

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Griffith Evan Hild
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 14, 1870

8. AGE: Years	Months	Days	If less than one day
76	5	22	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation –
11. Industry or business

FATHER
12. Name Rufus W. Suter
13. Birthplace Hagerstown, Md.

MOTHER
14. Maiden Name Mary Beck
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Harry E. Suter
(b) Address 2870 Woodbrook Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/9/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date rec'd by local reg. APR 9 1947 (b) Registrar Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6, 1947, at 3:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 2, 1947 to April 6, 1947.
and that I last saw him alive on April 4, 1947.

Immediate cause of death	Duration
Cerebral thrombosis	5 days
Due to Chronic Glomerulo Nephritis	4 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry E. Suter M.D.
Address Date signed 4/8/47

C50519

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1164a

C50519 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3608 Greenmount Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM MILLER RUTY

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Viola M. Ruty
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1889

8. AGE: Years	Months	Days	If less than one day
57	5	28	hr. min.

9. Birthplace New Orleans, La.
(Town, county, and state)
10. Usual Occupation Contractor
11. Industry or business Self

FATHER
12. Name Ernest Ruty
13. Birthplace New Orleans

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Maybell Ruty
(b) Address 3608 Greenmount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/12/47 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem.
Location Balto., Md.

18 (a) Funeral director Edw. J. Dickey & Sons
(b) Address North & Penna Aves.

APR 9 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8, 1947, at 9 a. M.

21. I certify that I took charge of the remains described above, held an insp. & inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation by hanging
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-8-47 at about 8.30 a. M.
(b) Where did injury occur? 3608 Greenmount Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Hanging by rope

23. Signature Earl K. Ryan M.D.
Medical Examiner.
Date signed 4-8-47

G50520 261

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 4/61

Registered No. G50520

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MARYLAND GENERAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Brooklyn Park (If outside city or town limits, write RURAL and give town)
(d) Street No. 2 South Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELSIE ARNDT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Herman J. Arndt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 27 1888

8. AGE: Years 58 | Months 6 | Days 9 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Home - Wife

11. Industry or business

FATHER
12. Name Wiskall
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace Germany

16 (a) Informant Herman J. Arndt
(b) Address 2 10th Ave. Brooklyn Park

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/10/47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location B.P.C.

18 (a) Funeral director C. J. Fanning & Son
(b) Address 1938 E. Lafayette Ave.

PR 9 1947 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/5 1947, at 10:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/5 1947 to 4/5 1947. and that I last saw her alive on 4/5 1947.

Immediate cause of death	Duration
DIABETIC ACIDOSIS	12 Hrs.
Due to DIABETES MELLITUS	
Due to	
Other Conditions CARDIAC DECOMPENSATION (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles W. Stewart, Jr. M.D.

Address MARYLAND GEN. HOSP. Date signed 4/5/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50521 (top right)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G50521 1172 V13B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Union Memorial Hosp
(c) Hospital or institution: Calvert + 33rd Sts
(d) Length of stay in hospital or inst. (~~years~~ ~~months~~ ~~days~~) 5
(e) Length of stay in Baltimore (~~years~~ ~~months~~ ~~days~~) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1706 N. CALVERT ST (If ~~rural~~ give location)
(e) Citizen of foreign country? ~~No~~ (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE JOSEPH RIORDAN, JR

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Emily M. Riordan
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) 6/6/1901

8. AGE: Years	Months	Days	If less than one day
45	11 10	2	— hr. — min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Real Estate
11. Industry or business

FATHER
12. Name GEORGE JOSEPH RIORDAN
13. Birthplace MARYLAND

MOTHER
14. Maiden Name FLORENCE —
15. Birthplace —

16 (a) Informant DECEASED
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-10-47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cemetery
Location

18 (a) Funeral Director Edgar B. Woodward Funeral Home Inc.
(b) Address 40 [illegible]

APR 9 1947 (Date rec'd Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/8/1947, at 7:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/3/1947 to 4/8/1947 and that I last saw h~~im~~ alive on 4/8/1947

Immediate cause of death Pulmonary tuberculosis — Duration 2 yrs+
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Crawford W. Kirkpatrick Jr. M.D.
Address Union Memorial Hosp. Date signed 4-8-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50522

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G50522
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2913 Guilford Ave.
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 70yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2913 Guilford Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Kernan

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Philip E. Kernan Sr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 9, 1856

8. AGE: Years	Months	Days	If less than one day
90	3	30	hr. min.

9. Birthplace Tefar, Baltimore Co, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Patrick Fitzgerald
13. Birthplace Ireland

MOTHER
14. Maiden Name Brigid Kelly
15. Birthplace Ireland

16 (a) Informant Miss Janet Kernan
(b) Address 2913 Guilford Ave

17 (a) Burial (b) Date thereof 4/8/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ New Cathedral
Location Baltimore, Md

18 (a) Funeral director H. W. Meades and Son
(b) Address 805 N. Calvert St.

19 (a) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

APR 9 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1947, at 12 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 3 1946 to April 7 1947, and that I last saw h~~er~~ alive on April 4 1947.

Immediate cause of death	Duration
Senility	7 mos
Due to Generalized arterio-sclerosis	7 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frederick J. Valliere M. D.
Address 6100 York Road Date signed April 7 '47

X

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G50523

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

G50523 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 223 N. Durham St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 223 N. Durham St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary L. Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Newman Brown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11, 1889

8. AGE: Years 57 | Months 10 | Days 25 | If less than one day hr. min.

9. Birthplace Brunswick Edward Co. Va. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Henry Jackson

13. Birthplace Va

MOTHER 14. Maiden Name Margaret Jackson

15. Birthplace Va

16 (a) Informant John Smith

(b) Address 223 N. Durham St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 10, 47 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem

Location Brooklyn Md

18 (a) Funeral director Elroy Dickson

(b) Address 1005 Brantley Rd

19 (a) 1947 (Date received by registrar) (b) Registrar

Huntington Williams, MD

VS 150

4/5/47 **MEDICAL CERTIFICATION** 9 AM

20. DATE OF DEATH April 5 1947 at 9 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1946 to April 5 1947 and that I last saw h alive on 19

Immediate cause of death Acute Coronary Thrombosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
June.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irene A Johnson M. D.

Address 2329 Guilford Ave Date signed April 9 1947

X

G50524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G50524 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3915 Ridgewood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3915 Ridgewood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: James Edward Engelman, Sr.

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: No

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Katherine Vetter Engelman

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) June 20, 1874

8. AGE: Years 72 | Months 9 | Days 17 | If less than one day ..... hr. ..... min.

9. Birthplace Cumberland, Md.
(Town, county, and state)

10. Usual Occupation Restaurant Owner

11. Industry or business

FATHER
12. Name Jacob Engelman
13. Birthplace Philadelphia, Pa.

MOTHER
14. Maiden Name Alice Virginia Mallory
15. Birthplace Orange, Va.

16 (a) Informant Mrs. Katherine Engelman
(b) Address 3915 Ridgewood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 10, 1947 (month) (day) (year)
(c) Cemetery or crematory London Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director Miller Lamonaca
(b) Address 4510 Liberty Heights Ave.

19 (a) (Date received by registrar) Huntington Williams Registrar

APR 9 1947

150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1947, at 2.30P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-6-1947 to 4-7 1947 and that I last saw h im alive on 4-7 1947,

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to Hypertension	5 yr
Due to Arteriosclerosis	—
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howard F. Warren M. D.
Address 2604 Garrison Blvd. Date signed 4-5-47

X

G50525 DC # 44638

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G50525 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Light St.
(c) Hospital or institution: So Balto Gen Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Brooklyn and (If outside city or town limits, write RURAL and give town)
(d) Street No. Route 1 Box 244 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Raoul Brickman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 31-46

8. AGE: Years	Months	Days	If less than one day
1	-	8	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Raoul Brickman
13. Birthplace Russia

MOTHER
14. Maiden Name Alide Linz
15. Birthplace Penna.

16 (a) Informant Raoul Brickman.
(b) Address Route 1 Box 244 - 25 -

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/11/47. (month) (day) (year)
(c) Cemetery or crematory Glen Haven Memorial Park
Location Gov. Ritchie Highway (Glenburnie)

18 (a) Funeral director Milton Schilling
(b) Address 3914 Hanover St.

19 (a) APR 9 1947 (b) (Signature) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-8 1947 at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-7 1947 to 4-8 1947 and that I last saw h[illegible] alive on 4-8 1947.

Immediate cause of death	Duration
(a) Acute Laryngo-Tracheo-Bronchitis	
Due to DIPHTHERIA	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1217 Light St Date signed 4-8-47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50526

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V124B

G50526 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 59 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3702 Elkader Rd.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Duvall, Wirt Adams, Jr.

3 (b) If veteran, name war: WW I
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Married

6 (b) Name of husband or wife: Shirley Gross Duvall
6 (c) If alive, give age (46) years

7. Birth date of deceased (mo., day, yr.) Oct. 26, 1896

8. AGE: Years	Months	Days	If less than one day
50	5	13	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Attorney
11. Industry or business

FATHER
12. Name Wirt Adams Duvall
13. Birthplace Anne Arundel Co. Md.

MOTHER
14. Maiden Name Roxanna Mitchell
15. Birthplace Baltimore, Md. (?)

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (b) Date thereof 4/11/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) 1947 (b) [illegible] Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1947, at 5:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 8 1947, to Apr. 8 1947 and that I last saw h im alive on Apr. 8 1947.

Immediate cause of death: Cirrhosis of liver — Duration: UNKNOWN

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 4/9/47

VS 150

G50527

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1951

G50527 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 655 PORTLAND ST.
(c) Hospital or institution: ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days) ✓

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County ✓
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 655 PORTLAND ST.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME PREXIDA A. URBONAS. (GRABONAWICH)

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. married.

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 28 188?

8. AGE: Years 64 | Months 65 | Days 5 14/10 | If less than one day ..... hr. ..... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business .....

FATHER
12. Name Unknown.
13. Birthplace .....

MOTHER
14. Maiden Name Unknown.
15. Birthplace .....

16 (a) Informant Steve Burns. (URBONAS)
(b) Address .....

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4-10-47 (month) (day) (year)
(c) Cemetery ~~crematory~~ HOLY REDEEMER
Location BELAIR ROAD.

18 (a) Funeral director Charles W. Kackmeister
(b) Address 703 McHENRY ST.

19 (a) 1947 (Date received by registrar) Evelyn Williams, Registrar

APR 9

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 7 1947, at 9'15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1/46 19.. to 4/7/47 19.., and that I last saw her alive on 4/7/47 19..

Immediate cause of death	Duration
Congestive Heart Failure	2 Years
Due to Rheumatic Heart Disease	Years
Due to	Years
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature C. J. Manaklas M.D.
Address 651 N. Bentalou Str Date signed 4/9/47

X

G50528

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G50528

Registered No. 83a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7101 W. Cold Spring Lane
(c) Hospital or institution: Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 Mos
(e) Length of stay in Baltimore (yrs., mos., or days) 10 Mos

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County St. Mary's
(c) City or town LEONARD TOWN
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph A. Long

3 (b) If veteran, name war –

3 (c) Social Security Account No. –

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. WIDOWED

6 (b) Name of husband or wife MONICA M. LONG

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 1- 1860

8. AGE: Years 86 | Months 10 | Days 8 | If less than one day hr. min.

9. Birthplace LEONARDTOWN MD (Town, county, and state)

10. Usual Occupation RETIRED

11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace CHARLES CO. MD

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace CHARLES. CO. MD

16 (a) Informant THOMAS G. LONG
(b) Address 2701 CLEVERLY AVE CLEVERLY MD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APRIL 11-1947 (month) (day) (year)
(c) Cemetery or crematory CEDAR HILL
Location [redacted] Md.

18 (a) Funeral director Chas. J. Cragg Son
(b) Address 118 N. Mt. Royal Ave

19 (a) APR 9 1947 (Date received by registrar) Huntington Williams Md Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/9 1947 at 6:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-15 1946 to 4-9 1947 and that I last saw him alive on 4-8 1947

Immediate cause of death CEREBRAL HEMORRHAGE — Duration – 5 days

Due to ARTERIOSCLEROSIS — 10 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman R. Klenman M.D.
Address 3803 Edmondson Ave Date signed 4/9/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G50529

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3424 Wilkens Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25-1
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3424 Wilkens Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dietrich Hesterberg

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elizabeth Hesterberg
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19, 1870

8. AGE: Years 76 | Months 10 | Days 20 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Blacksmith
11. Industry or business Retired

FATHER
12. Name Christian Hesterberg
13. Birthplace Germany

MOTHER
14. Maiden Name Sophie Seichting
15. Birthplace Germany

16 (a) Informant Elizabeth Hesterberg
(b) Address 3424 Wilkens Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-12-47 (month) (day) (year)
(c) Cemetery or crematory St. Paul's
Location Catonsville

18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Ave.

19 (a) Filed APR 10 1947 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8, 1947, at 4 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from January 1 1947, to April 8 1947, and that I last saw him alive on April 2 1947

Immediate cause of death: Coronary occlusion

Due to: Cardio Vascular disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:

of autopsy:

Duration: the Mos

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jos McKieffer M. D.
Address 2470 Mark Blvd Date signed 4-8-47

X

G50530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G50530

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 430 Annabel Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25+
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 430 Annabel Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Ernest Chaney

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-09-2180

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 11th 1883

8. AGE: Years	Months	Days	If less than one day
63	7	26	hr. min.

9. Birthplace Odenton Md.
(Town, county, and state)
10. Usual Occupation Handy man
11. Industry or business

FATHER
12. Name James A. Chaney
13. Birthplace Sappington Md.

MOTHER
14. Maiden Name Eliza C. Watts
15. Birthplace Sulphur Springs Md.

16 (a) Informant Edward E. Griffith
(b) Address 430 Annabel Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/10/47 (month) (day) (year)
(c) Cemetery or crematory Bethel
Location Fort Meade Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul Huntington Baltimore, Md.

19 (a) APR 10 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/7 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/4 1947 to 4/7 1947 and that I last saw h[illegible] alive on 4/5/ 1947.

Immediate cause of death	Duration
Cardiac thrombosis	10 hr
Due to Arterio Scl	6 mo
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. J. Hawkins M.D.
Address 6 Randall St Date signed 4/9/47

VS 150

G50531

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. G50531

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Linden & Madison Ave

(c) Hospital or institution: Maryland General Hospital W-3

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 868 Park Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mary E. May

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 18, 1896

8. AGE: Years 50 | Months 11 | Days 20 | If less than one day 19 hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Dressmaker

11. Industry or business

FATHER 12. Name Milton May

13. Birthplace Virginia

MOTHER 14. Maiden Name Martha Fawkley

15. Birthplace Virginia

16 (a) Informant Robert E. Wright

(b) Address 922 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/11/47 (month) (day) (year)

(c) Cemetery or crematory Morland Park

Location Parkville Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul St

19 APR 10 1947 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1947, at 6:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/30 1947, to 4/7 1947, and that I last saw her alive on 4/7 1947.

Immediate cause of death	Duration
Carcinoma of cervix	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Morton C. Kemp Jr. M.D.

Address Md. Gen. Hosp. Date signed

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

G50532 BP# B75331 CERTIFICATE OF DEATH 160A Registered No. G50532

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green Sts
(c) Hospital or institution: University Hospital. 9-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3601 Old York Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Russell

3 (b) If veteran, name war —
3 (c) Social Security Account No. NONE

4. Sex F. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-7-47

8. AGE: Years | Months | Days 1 day | If less than one day 1 hr. 45 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Wm F. Russell Jr.
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Margaret Correlli
15. Birthplace Balto. Md.

16 (a) Informant William Russell
(b) Address 3601 Old York Rd.

17 (a) Burial (b) Date thereof 4/10/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Moreland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 APR 10 1947 Huntington Williams, M.D.
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-8-47 1947, at 5:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-7 1947, to 4-8 1947, and that I last saw her alive on 4-8 1947.

Immediate cause of death Respiratory failure — Duration
Due to Intracranial hemorrhage
Due to Birth trauma
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. H. Vaughan, M.D.
Address Univ. Hospital Date signed 4-9-47

VS 160

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50533
TN. 50726

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 186a

Registered No. G50533

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-mo. 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore Lansdowne
(If outside city or town limits, write RURAL and give town)
(d) Street No. Balto Highlands Lansdowne Post Office (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susan Hall

3 (b) If veteran, name war —
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2nd 1866

8. AGE: Years 80 | Months 9 | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Patrick Greene (D
13. Birthplace England

MOTHER
14. Maiden Name Kate Fern (D
15. Birthplace Ireland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 11th 1947 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A. A. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) Filed APR 10 1947 (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8th/1947, at 9.10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 4th 1946 to Apr. 8/1947, and that I last saw h er alive on Apr/8th 1947.

Immediate cause of death	Duration
Bronchopneumonia	8 days
Due to	
Due to Hypertensive C-V disease Generalized atherosclerosis Intertrochanteric fracture right femur	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 2/25/1947
Major findings of operation: none — reaction following application of cast.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 26/12
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 2/21/1947 at 10:00 P. M
(c) Where did injury occur? Baltimore, Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Balt. City Infirmary While at work? no
(Specify type of place)
(e) Means of injury Cane slipped & patient fell

23. Signature H. H. Hobbs M. D.
Address Baltimore City Hospitals Date signed 4/5/1947

X Earl L. Royer M.D.

VS 150

G50534

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G50534

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1717 W. Mulberry Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1717 W. Mulberry St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) **FULL NAME** Ruby Bland

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: George Bland
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1900

8. AGE: Years	Months	Days	If less than one day
46	3	14	hr. min.

9. Birthplace EASTERN Shore Maryland (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name William White
13. Birthplace Maryland

MOTHER
14. Maiden Name Julia Colborn
15. Birthplace MARYLAND

16 (a) Informant George Bland
(b) Address 1717 W. Mulberry Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 8th 47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location Elmer O Wilson

18 (a) Funeral director
(b) Address 1000 Brantley Ave

19 (a) APR 10 1947 Huntington Nottingham M.D. (Date received) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1947, at 1:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from MARCH 25 1947, to April 8 1947, and that I last saw her alive on April 6 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	week
Due to Hypertensive Heart Disease	Several yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard H. Hunt M. D.
Address 1631 W. Franklin St. Date signed 4-9-47

X

G50535

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G50535

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1710 John St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1710 John St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Howard Este Gilbert

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 30 1873

8. AGE: Years 73 | Months 9 | Days 8 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Retired Clerk

11. Industry or business Maryland Oil Co

FATHER
12. Name Isaac Clark Gilbert
13. Birthplace Md

MOTHER
14. Maiden Name Martha J Treadwell
15. Birthplace Md

16 (a) Informant Mrs Mary F Beyer
(b) Address 850 W 36 st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-10-47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Geo F Beyer Jr
(b) Address 1512 Hollins St

19 (a) Date received APR 10 1947 Huntington Williams Mgr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1947 at 9 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1927 to April 1947 and that I last saw h alive on 4/8 1947

Immediate cause of death: Carcinomatosis — Duration: 3 da

Due to: Myocarditis — 5 yrs

Due to: —

Other Conditions: Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature J. Talbott

Address 2723 St Paul St Date signed 4/8/47 M. D.

VS 150

050536 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 050536

CERTIFICATE OF DEATH 1939

Registered No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH
CITY OF BALTIMORE: (No. 1700 Park ave St. ..... Ward)

Length of residence in city or town where death occurred ..... yrs. Life mos. ..... da. How long in U. S. If of foreign birth? ..... yrs. ..... mos. ..... da.

If U. S. Veteran specify WAR .....

2. FULL NAME Ella E. Stansbury

(a) Residence: No. 1700 Park ave St., 14-1 Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year) 12/20/1864

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	82	3	18	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. at Home

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. .....

10. Date deceased last worked at this occupation (month and year) .....

11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (city or town) (State or country) Balto Md

FATHER

13. NAME John E Stansbury

14. BIRTHPLACE (city or town) (State or country) Md

MOTHER

15. MAIDEN NAME Pole

16. BIRTHPLACE (city or town) (State or country) Md

17. INFORMANT Mrs John Stansbury
(Address) 3912 Oakford ave

18. BURIAL, CREMATION, OR REMOVAL
Place Druid Ridge Date 4/10/47 19

19. UNDERTAKER Geo L Berger Sr
(Address) 15-12 Hollins st

20. FILED APR 10 1947 Huntington Williams, M.D. Registrar.

VS 3

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) April 8 1947

22. I HEREBY CERTIFY, That I attended deceased from July 1935 to April 8 1947
I last saw her alive on April 8 1947 Death is said to have occurred on the date stated above, at 5 P m.

The principal cause of death and related causes of importance were as follows:

	Duration
Myocarditis	Contributory
Arterio Sclerosis	2

Other contributory causes of importance .....

Was an operation performed? ..... Date of .....

For what disease or injury? .....

Name of operation .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ..... 19.....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased?
If so, specify .....

(Signed) W H Hoadley M. D.

(Address) 1402 Park Ave

X

G50537

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G50537

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 S. Hanover St
(c) Hospital or institution: 23
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1211 S. Hanover St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frederick W. Peterson

3 (b) If veteran, name war World War I

3 (c) Social Security Account No. 214-03-5334

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married —

6 (b) Name of husband or wife Sarah E. Peterson (nee Spencer)

6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) Nov-4-1897

8. AGE: Years 49 | Months 5 | Days 7 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Butcher

11. Industry or business Own Business

FATHER
12. Name Nicholas Peterson
13. Birthplace Denmark

MOTHER
14. Maiden Name Julia J. Ellinhaus
15. Birthplace Germany —

16 (a) Informant Mrs. Sarah E. Peterson (Wife) 22
(b) Address 711 Bonaparte Balto 39 Md

17 (a) Burial — (Burial, cremation, or removal) (b) Date thereof Apr 12, 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Balto Co. Md

18 (a) Funeral director J. Howard Evans
(b) Address 1400 S. Charles St Balto 39 Md

19 APR 10 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/6 1947 at 10:35 A.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22 If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

C. P. Fulmer M.D. Signature Medical Examiner.
Date signed 4/9/47

G50538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G50538

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 Patapsco St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23-2
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs 4 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto City
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 Patapsco St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Samuel Abmansa Forrest

3 (b) If veteran, name war No | 3 (c) Social Security Account No. No

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Elvesta M. Forrest

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 17, 1876

8. AGE: Years 71 | Months 2 | Days 22 | If less than one day hr. min.

9. Birthplace Frederick Co Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

MOTHER / FATHER

12. Name Daniel W. Forrest

13. Birthplace Md

14. Maiden Name Dazt Snow

15. Birthplace Md

16 (a) Informant Daniel W. Forrest

(b) Address 1400 Patapsco St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 12, 1947 (month) (day) (year)

(c) Cemetery or crematory Methodist Ch 900 Bethel Mt Bentley

Location Frederick Co. Md.

18 (a) Funeral director C. Bowley Evans

(b) Address 26 Lewis St

19 (a) APR 10 1947 (Date rec'd by registrar) (b) Huntington Williams Md

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1947 at 3:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to April 9 1947 and that I last saw him alive on 4/9/47 19

Immediate cause of death	Duration
Pulmonary Edema	12 hrs
Due to Chronic Myocarditis	2
Due to Arteriosclerosis	2
Other Conditions Natural Causes	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Eractus Kohn M.D.

Address 1020 Fort Ave. Date signed 4/11/47

VS 150

X

G50539

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G50539

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 303 Tuscany Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 303 Tuscany Road (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jeannie Brown-Hancock Crawford

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife W. C. Crawford

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 7, 1896

8. AGE: Years	Months	Days	If less than one day
50 51	8 7	1	hr. min.

9. Birthplace Richmond Va (Town, county, and state)

10. Usual Occupation House-wife

11. Industry or business

FATHER
12. Name Albert J. Hancock
13. Birthplace Atlanta, Ga.

MOTHER
14. Maiden Name Corinna Boyd
15. Birthplace Atlanta, Ga.

16 (a) Informant W. C. Crawford
(b) Address 303 Tuscany Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 10 47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Frankslintown

18 (a) Funeral director John D. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) APR 10 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-8-1947, at 6 45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Suffocation (choking)

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 12/1

(a) Date of injury 4-8-47 at 6:40 P.M.
(b) Where did injury occur? 303 Tuscany Road
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Bolus of food

23. Signature Howard J. Haddaway M.D. Medical Examiner.
Date signed 4-8-47

G50540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G50540 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd St Calvert
(c) Hospital or institution: Union Memorial Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4709 Roland Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3 (a) **FULL NAME** Mrs Frances Hall Culver

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Mar

6 (b) Name of husband or wife Francis B. Culver
6 (c) If alive, give age 2 years

7. Birth date of deceased (mo., day, yr.) Nov 19, 1884

8. AGE: Years 62 | Months 4 | Days 20 | If less than one day 19 hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Nurse

11. Industry or business

FATHER
12. Name John Hall
13. Birthplace Baltimore

MOTHER
14. Maiden Name Sophia Groscup
15. Birthplace Baltimore

16 (a) Informant Francis B. Culver
(b) Address 4709 Roland Ave, City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 10 '47 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Green Mount & North Ave.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1960 Eutaw Place

19 APR 10 1947 (Date rec'd by registrar) (b) Huntington Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1947, at 2:40 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-6 1947 to 4-8 1947, and that I last saw her alive on 4-7 1947.

Immediate cause of death	Duration
Hemorrhage from vessel of brain & left hemiplegia	2 days
Due to Hypertension cardio vascular disease	yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Norman R. Freeman M.D.
Address Union Memorial Hosp. Date signed April 8, '47

X

650541

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 650541

195E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 323 Caudry Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER Z. KLUSEWITZ

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-46-4466

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1923

8. AGE: Years	Months	Days	If less than one day
24			hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Glen Martin

FATHER
12. Name Thomas
13. Birthplace Pa.

MOTHER
14. Maiden Name Karolina Majdarek
15. Birthplace Poland

16 (a) Informant Ida Kratz
(b) Address 323 Caudry Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 12/47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore

18 (a) Funeral director Fred W. Ozazewski
(b) Address 1900 Eastern Ave

19 (a) APR 10 1947 (Date rec'd by registrar) (b) Hunter for Williams M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9, 1947, at 8 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☒ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Fracture of skull
Intracranial hemorrhage

Due to
See amended certificate - Reverse side.

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 4/9/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C50542

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. C50542

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 131 S. Collins Ave.
(c) Hospital or institution:
20
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 131 S. Collins Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara J. Becker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late Emil Becker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6, 1874.

8. AGE: Years	Months	Days	If less than one day
73	1	1	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Weidemann
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Louis J. O. Becker
(b) Address 8059 Roslyn Ave. Balto. 6, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 10/47 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave. & Longwood St.

18 (a) Funeral director Harry A. Wittle
(b) Address 4101 Edmondson Ave.

19 APR 10 1947 (Date rec'd by Reg.) Washington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7/47. 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/04/ 1944, to 4/7/ 1947
and that I last saw h[illegible] alive on 4/7/ 1947

Immediate cause of death Myocarditis & Chr Heart Block — Duration: 3 yrs

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation No

Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Lloyd Johnson M. D.
Address Catonsville Date signed 4/9/47

G50543

AD-109710 Bl# B69536 /107

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G50543 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 16 N. Bruce Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Arnold Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25-1947

8. AGE: Years | Months 2 | Days 15 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert Dorsey
13. Birthplace Maryland

MOTHER
14. Maiden Name Elsie Johnson
15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 10 1947 (month) (day) (year)
(c) Cemetery or crematory Asbury Memorial Park
Location

18 (a) Funeral director Irvin Nathan R. Williams
(b) Address 322 N. Schroeder St.

19 APR 10 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION AM

20. DATE OF DEATH April 8- 1947, at 11.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-7 1947, to 4-8 1947, and that I last saw h. 1m alive on 4-8- 1947

Immediate cause of death: Bronchopneumonia ? — Duration 3 days

Due to

Due to

Other Conditions Malnutrition and Dehydration } — 10 days
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: Atelectasis, Bronchopneumonia ?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Julian P. Pinsker M. D.
Address Balt City Hosp Date signed 8 Apr 1947

VS 150

G50544 B# B-57497

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G50544

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 14 2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1403 Myrtle Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Nathan Hyman.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife ~

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1946

8. AGE: Years ~ | Months 6 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore, Md.,
(Town, county, and state)

10. Usual Occupation ~

11. Industry or business

FATHER
12. Name Nathan Hyman.
13. Birthplace N.C.

MOTHER
14. Maiden Name Mildred Bradley
15. Birthplace Scotland Neck, N.C.

16 (a) Informant Ethel Williams
(b) Address 1303 Myrtle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 10 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn.
Location

18 (a) Funeral director Mrs. Katie R. Willis
(b) Address 322 N. Schroeder St.

1947 APR 10 (Date rec'd by Reg'r) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1947, at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pulmonary tuberculosis,
with miliary spread.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 4/8/47

VS 181

G50545 HARRIS, Levy G50515

510698

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46H

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 15-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) Hardly
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4413 Roren Harkard (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harris Levy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rose Levy

6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 67 | Months 8 | Days | If less than one day ____hr. ____min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Louis Levy
13. Birthplace Russia

MOTHER 14. Maiden Name Michle ?
15. Birthplace Russia

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-10-47 (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh
Location Windsor Mill Road

18 (a) Funeral director Jack Levin Inc
(b) Address 4316 Park Ave

19 APR 10 1947 (b) Huntingdon Williams, M.D. (Registered by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-9-1947 at 8:15 P M

21. I certify that death occurred on the date above stated: that I attended deceased from Feb 28 1947 to Apr 9 1947 and that I last saw him alive on Apr 9 1947.

Immediate cause of death: Cardiac Failure and

Due to: Carcinomatosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation Feb 28, 1947

Major findings of operation: Carcinoma Tons peritonei

of autopsy:

Duration
2 weeks
2 years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas N P Johns M. D.
Address Johns Hopkins Hosp. Date signed Apr 9, 47

VS 150

X

650546

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No. G50546

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given. Fill in all blanks. Be sure the causes of death clearly and legibly. Give full name of deceased, and if a married woman, the name of her husband. Give correct age in years, months, days, hours, or minutes. Physicians: please write the causes of death clearly and legibly. Be sure to answer all questions, and especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1417 N. Washington Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Baker

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-09-3441

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Sarah Baker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years	Months	Days	If less than one day
81			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Brick Mason
11. Industry or business Brick Yard

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Earl J Davis
(b) Address U.S.A. Service

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Apr. 11 47 (month) (day) (year)
(c) Cemetery or crematory Manchester
Location Manchester. Md

18 (a) Funeral director Geo M. Fenwick Son
(b) Address 511 N Wolfe St

19 (a) APR 10 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8, 1947 at 6 10 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral edema

Due to

Other Conditions Fractures, both tibiae and fibulae, Fractured right humerus
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury 4/2/47 at 4 45 A. 8/7 M.
(b) Where did injury occur? 1460 blk. North Washington St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury: Pedestrian struck by auto

23. Signature Carl L Royer M.D.
Medical Examiner.
Date signed 4/9/47

X

G50547

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1131a

Registered No. G50547

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 643 S. Lehigh St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 643 S. Lehigh St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAMIE ALICE DAVIS

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Charles H. Davis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 24 1900

8. AGE: Years	Months	Days	If less than one day
47	2	16	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Edgar Kidwell
13. Birthplace Va.

MOTHER
14. Maiden Name Della Gibson
15. Birthplace Va.

16 (a) Informant Mr. Charles H. Davis
(b) Address 643 S. Lehigh St.

17 (a) Burial (b) Date thereof 4/12/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oaklawn Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) APR 10 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9, 1947, at 6:40a M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 1947 to April 9 1947
and that I last saw h[illegible] alive on April 8 1947

Immediate cause of death: Cerebral Apoplexy — Duration 2 mos (last one)
Due to Cerebral Arterio-Sclerosis
Due to Chr. Nephritis
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mary H. Reynolds M.D.
Address 202 W. Lafayette Ave Date signed 4/9/47

X

G50548

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G50548

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 513 Walker Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 513 Walker Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY LOUISE LONG

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife George H. Long
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 11, 1858

8. AGE: Years	Months	Days	If less than one day
88	6	28	hr. min.

9. Birthplace Cincinnati, Ohio
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Frank Polser
13. Birthplace Pa.

MOTHER
14. Maiden Name Ellen Pryor
15. Birthplace Cincinnati, Ohio

16 (a) Informant Mrs. Foster B. Davis, daughter
(b) Address 513 Walker Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4/10/47 (month) (day) (year)
(c) Cemetery or crematory Woodla wn Cem.
Location Lima, Ohio

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) APR 10 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 1944 to April 9 1947, and that I last saw her alive on April 7 1947.

Immediate cause of death	Duration
Chronic Myocarditis	3 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 6014 York Road Date signed 4-10-47

X

G50549

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

G50549 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Hospital 3 +
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 months
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1003 Stiles St. (If rural give location)
(e) Citizen of foreign country? .....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Rosario Arcidiacono

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-10-0874

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mrs. Jennie Arcidiacono
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Nov 6 1888

8. AGE: Years 58 | Months 5 | Days 3 | If less than one day ... hr. 15 min.

9. Birthplace Italy (town, county, and state)

10. Usual Occupation Stonemason

11. Industry or business

FATHER 12. Name Rosario Arcidiacono
13. Birthplace Italy

MOTHER 14. Maiden Name Sara —
15. Birthplace Italy

16 (a) Informant Mercy Hospital
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/11-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Dolle Sons
(b) Address 52 N. Morley St.

APR 10 1947 (b) Huntington Williams, Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1947, at 1 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 22 1946 to 4-9 1947, and that I last saw h[illegible] alive on 4-9 1947.

Immediate cause of death: Papillary Carcinoma of Rectum — Duration .....
Due to: .....
Due to: .....
Other Conditions: .....
(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury.....

23. Signature Lawrence J. Knott M.D.
Address Mercy Hospital Date signed 4-9

VS 150

G50550 BALTIMORE CITY HEALTH DEPARTMENT G50550
CERTIFICATE OF DEATH 46B Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 695-W. Mulberry St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 695-W. Mulberry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country no

3 (a) **FULL NAME** Albert Waters

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male | 5. Color or race colored | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Agnes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15, 1887

8. AGE: Years 60 | Months - | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Md. Glass Co.

FATHER 12. Name unknown

13. Birthplace North Carolina

MOTHER 14. Maiden Name Unknown

15. Birthplace North Carolina

16 (a) Informant Frank Grnish

(b) Address 637-W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-11-47 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cemet.

Location Cedar Hill Md.

18 (a) Funeral director G. Halstead

(b) Address 918 Druid Hill Ave.

19 (a) APR 10 1947 (Date received by Registrar) Transfer for Williamsport, Md.

MEDICAL CERTIFICATION 30

20. DATE OF DEATH April 8, 1947, at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1947 to April 1947 and that I last saw ... alive on April 1947.

Immediate cause of death Arthur Carawan — Duration 6 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Cooper

Address [illegible] Date signed 4/10/47

VS 15G

G50551 FL - 109050

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G50551

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1562 Fremont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Gross

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4, 1868

8. AGE: Years	Months	Days	If less than one day
78	11	4	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-12-47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director George E. Nelson
(b) Address 300 Pennsylvania Ave

19 APR 10 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Address

MEDICAL CERTIFICATION P.M.

20. DATE OF DEATH April 8 1947, at 11:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 10 19 47 to Apr. 8 19 47 and that I last saw h. or alive on Apr. 8, 1947.

Immediate cause of death	Duration
Bronchopneumonia, left and right Lung, Abscess, Left upper lobe Lung	2 days
Due to Organisms, unidentified	1 month
Due to	
Other Conditions Arteriosclerotic Heart Disease (Include pregnancy within 3 months of death)	15 years

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Laurence Lee Jr. M. D.
Address Baltimore City Hosp. Date signed 4-9-47

VS 150

107

G50552 BCH

CWK-109164 B-73843

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

Registered No. G50552

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 19 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 927 N. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Yancy--Helen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15-1947

8. AGE: Years	Months	Days	If less than one day
		19	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robin Yancy
13. Birthplace Maryland

MOTHER
14. Maiden Name Helen ?
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 (a) APR 10 1947 Huntington Williams, M.D.
(Registered by registrar) Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH April 4 1947, at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mch. 15 1947, to Apr. 4 1947, and that I last saw h im alive on Apr. 4 1947.

Immediate cause of death: Prematurity — Duration: Stillborn

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wilson E. Hughes M. D.
Address Balto City Hosp Date signed Apr 8 '47

VS 150

G50553

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G50553

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1704 W. Franklin St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 d
(e) Length of stay in Baltimore (yrs., mos., or days) 4 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1704 W. Franklin St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Vaughn.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	Married

6 (b) Name of husband or wife Aria Johnson.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) November 25, 1879.

8. AGE: Years	Months	Days	If less than one day
67	4	12	hr. min.

9. Birthplace Chesterfield, Virginia. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Chesterfield, Va

FATHER
12. Name Albert Vaughn
13. Birthplace Chesterfield, Virginia.

MOTHER
14. Maiden Name Etta Vaughn
15. Birthplace Chesterfield, Va.

16 (a) Informant Aria J. Vaughn
(b) Address 1704 W. Franklin St

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof April 10 1947 (month) (day) (year)
(c) Cemetery or crematory Virginia
Location Virginia, Chesterfield

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 APR 10 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1947, at 9:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1947, to Jan 13 1947, and that I last saw h alive on Jan 13 1947.

Immediate cause of death	Duration
Valvular Heart Disease	1 yr
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Douglas Sleppard M. D.
Address 404 N Dulaney Date signed 4-10-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G50554 109243

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 110 B

G50554 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22days
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4 N. Poppleton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adelaide White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Fred White (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 29, 1880

8. AGE: Years 67 | Months 0 | Days 10 | If less than one day hr. min.

9. Birthplace N. J. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business at home

FATHER
12. Name Charles Robson
13. Birthplace England

MOTHER
14. Maiden Name Moror Blair
15. Birthplace N. Y.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 4/12/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location 1300 Frederick Rd.

18 (a) Funeral director Wm. H. Cowan & Son
(b) Address 1707-13 Collins Ave.

19 (a) APR 10 1947 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1947, at 4AM M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 17 1947 to Apr. 9 1947, and that I last saw h[illegible] alive on April 9 1947.

Immediate cause of death: Bronchopneumonia — Duration: 10 days

Due to: Decubitus ulcers

Due to: Fibrinous pleurisy, Rheumatoid arthritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. L. Gibbs M. D.
Address Baltimore City Hosp. Date signed 4/9/47

VS 150

G50555

BALTIMORE CITY HEALTH DEPARTMENT APR [illegible] 1947

CERTIFICATE OF DEATH ✓ 937

Registered No. G50555

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins 3-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 3 hours

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 423 S. Broad St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Michael Sikakun

3 (b) If veteran, name war .

3 (c) Social Security Account No. 212-10-1716

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER
12. Name.....
13. Birthplace Russia

MOTHER
14. Maiden Name.....
15. Birthplace Russia

16 (a) Informant John Malashuk
(b) Address 406 N. Rose St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-11-47 (month) (day) (year)
(c) Cemetery or crematory Russian Orthodox
Location A. A. Co.

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern Ave

19 (a) APR 10 1947 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/8/47 19.....4p M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular Disease

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature [illegible] Davis M.D. Medical Examiner.
Date signed 4/9/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 191

G50556

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G50556 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every question must be answered. Where the exact information is not known, approximate as nearly as possible. Where the causes of death clearly and legibly. Exact age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1224 Brentwood Ave
(c) Hospital or institution: 10-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dod.
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1224 Brentwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Chernock

3 (b) If veteran, name war

3 (c) Social Security Account No. 247-01-6649

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Esther
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years	Months	Days	If less than one day
45			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Cab Driver
11. Industry or business

FATHER
12. Name Meyrany
13. Birthplace Russia

MOTHER
14. Maiden Name Rose
15. Birthplace Russia

16 (a) Informant Esther Chernock
(b) Address 1224 Brentwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-10-47 (month) (day) (year)
(c) Cemetery or crematory
Location Prego Mt Carmel
18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E Baltimore St

APR 10 1947 (Date received by Registrar) (b) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9, 1947, at 8:30 P.M.

21. I certify that I took charge of the remains described above, held an Insp + Inq thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D. (Medical Examiner.)
Date signed 4-10-47

X

G50557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G50557

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1530 Homestead St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1630 Homestead St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie V. Guidice

3 (b) If veteran, name war: None
3 (c) Social Security Account No. no

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Jacob Guidice
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 19. 1876

8. AGE: Years 71 | Months 0 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation House work
11. Industry or business at home

FATHER
12. Name George Samuel
13. Birthplace Pa.

MOTHER
14. Maiden Name Elizabeth Riley
15. Birthplace Pa

16 (a) Informant Mrs Ann Johnson
(b) Address 1530 Homestead St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 12/47 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cemetery
Location 2330 Frederick Rd

18 (a) Funeral director Edgar W. Cumberland
(b) Address 2249 E. Eager St.

19 (a) Filed by registrar Huntington Williams M.D. Registrar

APR 10 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1947 at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1945 to April 9th 1947. and that I last saw h.e alive on April 8 1947.

Immediate cause of death	Duration
Coronary Thrombosis	2 hours
Due to Arteriosclerosis	—
Due to Hypertension, Chronic	2 yrs.
Other Conditions None.	—

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? No While at work? No (Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M. D.
Address 2824 St. Paul St. Date signed Apr. 10 '47

X

G50558

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G50558

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2620 E. Chase St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2620 E. Chase St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Elon E. Dryden

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-09-3616

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edna E. Dryden

6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) March 23, 1896

8. AGE: Years 51 | Months 0 | Days 16 | If less than one day ____ hr. ____ min.

9. Birthplace Somerset County, Md. (Town, county, and state)

10. Usual Occupation Receiver

11. Industry or business Balto. Transit Co.

FATHER
12. Name Woodland T. Dryden
13. Birthplace Somerset Co. Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Edna E. Dryden
(b) Address 2620 E. Chase St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/11/47 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location North Ave - Rose St.

18 (a) Funeral director John C. Miller Inc.
(b) Address 2435 E. Oliver St.

19 APR 10 1947 (Date rec'd by registrar) (b) Huntington Pittsburgh Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1947, at 10:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1 1947, to April 8 1947, and that I last saw him alive on April 8 1947.

	Duration
Immediate cause of death: Coronary Thrombosis	2 hours
Due to:	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Adam G. Sivers M. D.
Address 6232 Belair Road Date signed April 9, 1947

V S 150

C50559

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. C50559

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2324 E. Preston St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2324 E. Preston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Helen C. Kane ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/14/1892

8. AGE: Years	Months	Days	If less than one day
55	1	24	hr. min.

9. Birthplace Baltimore - Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Kane
13. Birthplace Ireland

MOTHER
14. Maiden Name Anne Foley
15. Birthplace Ireland

16 (a) Informant Margaret Brossoit
(b) Address 2324 E. Preston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/17/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Old Frederick Road

18 (a) Funeral director John C. Miller Inc.
(b) Address 2436 E. Oliver St

19 (a) APR 10 1947 (Date received by registrar) (b) Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/8 1947 at M

21. I certify that death occurred on the date above stated, that I attended deceased from 4-5 1947 to 4-7 1947 and that I last saw h alive on 4-7 1947

Immediate cause of death		Duration
	Lobar Pneumonia	4 days
Due to		
Due to	Acute Cardiac Dilatation	1 dy
Other Conditions		

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify)
(e) Means of injury

23. Signature Fred Rumig M. D.
Address 900 N. Patterson Date signed
Rx 4-9-47

BALZER

50560

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1481B

Registered No. G50560

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 121 N. East ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 121 N. East ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Balzer

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 14 1886

8. AGE: Years	Months	Days	If less than one day
61	1	24 21	hr. min.

9. Birthplace Ohio. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name William Balzer
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Lentz
15. Birthplace France

16 (a) Informant Jane Balzer (brother)
(b) Address 1217 East Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/10/47 (month) (day) (year)
(c) Cemetery or crematory Holy Rood
Location Belair Rd.

18 (a) Funeral director John A. Mahon
(b) Address 3600 E. Baltimore St.

19 (a) [illegible] Huntington Williams

APR 10 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1947 at 6 30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 7 1947 to April 7 1947, and that I last saw her alive on April 7 1947.

Immediate cause of death	Duration 20 MIN.
Coronary Embolism	
Due to Arterio Sclerosis Hypertension	1 YRS
Due to Chr Parenchymatous Nephritis	1 YRS
Other Conditions Cerebral Ulcer	1 YRS

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 2818 Harford Rd Date signed 4-8-47

G50561 Birth Certificate # 75292

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. G50561

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison
(c) Hospital or institution: Maryland General Hosp. 7-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 818 N. Gloven St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Klein, Babygirl

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	S.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/30/47

8. AGE: Years	Months	Days	If less than one day
		10	hr. min.

9. Birthplace Balto, Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Frederick Klein
13. Birthplace Md.

MOTHER
14. Maiden Name Cinga Gerhart
15. Birthplace Md.

16 (a) Informant Parents.
(b) Address 818 N. Gloven St.

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 4-10-1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Leo S. Cook
(b) Address 170-03 N. Patterson Park

19 (Date rec'd by registrar) APR 10 1947 Huntington Nelligan, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 9 1947 at 8 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 30 1947, to Apr 9 1947 and that I last saw her alive on Apr. 9 1947.

Immediate cause of death	Duration
Cardiac failure	
Due to Congenital heart disease.	
Due to	
Other Conditions Malnutrition (Sclerodema). (Include pregnancy within 3 months of death)	

Date of operation —
Major findings of operation: —
of autopsy: Congenital heart disease.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Francis L. Cook M. D.
Address Maryland Gen Hosp Date signed 4-9-47

VS 150

Dimber Robb

G50562

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

Registered No. G50562

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 647 W. Franklin St
(c) Hospital or institution: University of Maryland 17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 647 W. Franklin St (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Dimber Robb

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	col	married

6 (b) Name of husband or wife Isabelle Robb
6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) June 14 1882

8. AGE: Years	Months	Days	If less than one day
65	9 2	23	hr. min.

9. Birthplace Essex Co., Va (Town, county, and state)
10. Usual Occupation at Laundry
11. Industry or business Laborer

FATHER
12. Name Spencer Robb
13. Birthplace Essex Co. Va

MOTHER
14. Maiden Name Jennie Robb
15. Birthplace Essex Co. Va

16 (a) Informant Isabelle Robb
(b) Address 647 W. Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/11/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill Md.

18 (a) Funeral director A. Lofstead
(b) Address 968 Druid Hill Ave.

19 APR 10 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1947, at 12:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 7 1947, to April 7 1947, and that I last saw him alive on April 7 1947.

Immediate cause of death Pneumonia — with coma two days — Duration 1947

Due to Nephritis, shortness of breath since Feb

Due to

Other Conditions Shortness of Breath

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. B. Toland, M. D.
Address 926 W. Green Date signed 4-7-47
Howard J. Knudsen, M.D. X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50563

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. G50563

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2876 Pelham Ave.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2876 Pelham Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louise C. Mohr.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Alexander S. Mohr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 27, 1856

8. AGE: Years	Months	Days	If less than one day
90	7	7 12	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Gottleib Mattes
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Weis
15. Birthplace Germany

16 (a) Informant Miss Rose Mohr
(b) Address 2876 Pelham Ave.,

17 (a) Burail (b) Date thereof 4/11/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.,

19 APR 10 1947 (b) Huntington Williams, M.D.
(Date received by Registrar) (Registrar)

V S 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH April 8, 1947, at 12:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1940, to April 8 1947, and that I last saw her alive on April 7 19 47

Immediate cause of death Ch Myocarditis — Duration 10 yrs.
Due to Senility & Arteriosclerosis
Due to —
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. S. Harding M.D.
Address 4610 Belair Rd Date signed 4/9/47

X

G50564

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G50564

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution:
St. Josephs Hospital 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 74 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 114 S. Washington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. George Burkhardt

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Louise
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) May 28. 1872

8. AGE: Years	Months	Days	If less than one day
74	10	13	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Retired Merchant
11. Industry or business

FATHER
12. Name George Burkhardt
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Ullrich
15. Birthplace Germany

16 (a) Informant Geo A Burkhardt
(b) Address 1910 Mt Dorough St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 14 (month) (day) (year)
(c) Cemetery or crematory Pinewood Cem
Location Rural

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2005 Orleans St

19 (a) APR 10 1947 (Date received by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1947 19, at 4:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 8 19 47 to April 10 19 47
and that I last saw h alive on April 9 19 47

Immediate cause of death: cardiorespiratory failure — Duration

Due to Pulmonary Edema

Due to Cerebral Hemorrhage

Other Conditions arteriosclerosis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John B Weems M.D.
Address 1st Jos Hosp Date signed 4-10-47

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

Dr. G50565 99435

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G50565

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-mo. 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2011 Maisel St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Hoffman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 26th 1877

8. AGE: Years 69 | Months 13 | Days 12 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James (D.
13. Birthplace Maryland

MOTHER
14. Maiden Name Churchaw (D
15. Birthplace Maryland

16 (a) Informant Sam'l
(b) Address 2011 Maisel St.

17 (a) D. (Burial, cremation, or removal) (b) Date thereof 4-12-47 (month) (day) (year)
(c) Cemetery or crematory Westens
Location Balto. Md.

18 (a) Funeral director H. A. Tawes
(b) Address 1130 E. Fort Ave.

19 (a) APR 10 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 8th 1947, at 1.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 21/ 1946 to Apr. 8 1947, and that I last saw her alive on Apr. 8th 1947.

Immediate cause of death: Respiratory Failure — Duration (Day)
Due to: Bronchopneumonia
Due to:
Other Conditions: Hypertensive C V D
Auricular Fibrillation
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: — not performed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel B. Eastman M.D.
Address Balto Md Date signed 4-9-47

VS 150

107

C50566

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52 B

Registered No. C50566

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3820 Ednor Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 1
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3829 Ednor Road (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME JOSEPH MATTHEW BEAVIN

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of ~~husband~~ or wife Jeannette (nee Koebler)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5, 1879

8. AGE: Years	Months	Days	If less than one day
67	10	3	hr. min.

9. Birthplace Annapolis, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business Bethlehem Steel

FATHER
12. Name Eli Beavin
13. Birthplace Maryland

MOTHER
14. Maiden Name Elisa Curry
15. Birthplace Maryland

16 (a) Informant Elizabeth Eleanor Beavin - dgh
(b) Address 3820 Ednor Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/11/47 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Parkwood Cemetery
Location Taylor Ave., Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 APR 10 1947 by Thurston Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 8 1947, at 3 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1947, to Apr 8 1947, and that I last saw him alive on Apr 8 1947.

Immediate cause of death	Duration
Carcinoma of Bladder	4 mo
Due to Hemiplegia	
Due to Uremia	?
Other Conditions Contracture of Bladder Jan 20 1947. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature C W Mayer D
Address 1520 E 33rd St Date signed 4/9/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50567

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

√117a

Registered No. G50567

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Redwood St.
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Ppl

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2710 Pelham ave. #13
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles J. Kutcher, Jr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1929

8. AGE: Years	Months	Days	If less than one day
17	-4	-12	hr. min.

9. Birthplace Balto-Maryland
(Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER
12. Name Charles J. Kutcher, Sr.
13. Birthplace Md.

MOTHER
14. Maiden Name Eliz. Knorr
15. Birthplace Md.

16 (a) Informant Father
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/11/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (Date rec'd by registrar) APR 10 1947 Registrar Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-7 1947, at 11:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-6 1947 to 4-7 1947, and that I last saw h. alive on 4-7 1947.

Immediate cause of death	Duration
Cerebral anoxia due to respiratory depression with medullo intracranial pressure	
Due to midbrain neoplasm, probably Pineal Body	
Due to	
Other Conditions Subdural hematoma	

(Include pregnancy within 3 months of death)

Date of operation 4-7-47

Major findings of operation:

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Workman M. D.

Address Univ. Hosp. Date signed 4-8-47

VS 150

X

G50568 6th B 74784

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

160a

Registered No. G50568

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Also correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eastwood & Greene Sts.
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County B.A.Co. Md.
(c) City or town 242 Bishop Ave. (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore, Md. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Edward Love 4/2/47

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M.
5. Color or race Col.
6 (a) Single, married, widowed, or divorced. S.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/1/47

8. AGE: Years | Months | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business —

FATHER
12. Name John Wesley Love
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Sallie Mae Bays
15. Birthplace Baltimore, Md.

16 (a) Informant Sallie Mae Love
(b) Address 242 Bishop Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 10th (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cem.
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address

19 (Date received) APR 10 1947 (Registrar) Lod Brantley
Huntington Ave & Belair Rd

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1 1947 to 4/7 1947, and that I last saw him alive on 4-7 1947.

Immediate cause of death	Duration
Respiratory Failure	
Due to Intrauterine Lesion	
Due to Birth injury	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. A. Vaughan, Jr. M. D.
Address Univ. Hospital Date signed 4-7-47

G50569

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G50569 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 6 1/2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1507 E. Baltimore
(If rural give location)
(e) Citizen of foreign country? Finland (Yes or No)
If yes, name country

3 (a) FULL NAME Irene Brimm

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Black
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-15-17

8. AGE: Years 29 | Months 6 | Days 18 | If less than one day ___ hr. ___ min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James Harrison
13. Birthplace ?

MOTHER
14. Maiden Name Alice Bates
15. Birthplace ?

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 11, 47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location Baltimore Md
18 (a) Funeral director Cleary & Wilson
(b) Address 1010 Bentley Ave
19 (a) (Person acting as undertaker) (b) Date received APR 10 1947

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MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1947, at 10:07 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1947 to April 3 1947 and that I last saw her alive on April 3 1947.

Immediate cause of death: Miliary tuberculosis — Duration: ?
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dorothy H. Reamer M.D.
Address John Hopkins Hosp. Date signed April 5 1947

G50570

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G50570 Registered No.

1276

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County A. A.
(c) City or town Annapolis,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 118 Conduit
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Caterine~~ Catherine P. Sherman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Charles H. Sherman
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Oct 7 1883

8. AGE: Years	Months	Days	If less than one day
63	6	2 3	hr. min.

9. Birthplace Sousia Wales
(Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name William Moss
13. Birthplace Sousia Wales

MOTHER
14. Maiden Name Annie Williams
15. Birthplace Sousia Wales

16 (a) Informant Charles H Sherman
(b) Address 118 Coduit St Annapolis,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 12 1947 (month) (day) (year)
(c) Cemetery or crematory St Marys
Location Annapolis, Md.

18 (a) Funeral director B.L. Hopping & Son
(b) Address Annapolis, Md.

19 (a) Filed (b) Registered by registrar Thurston Williams, Registrar

APR 10 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 April 47 19 , at 11 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8 Apr 1947, to 9 Apr 1947, and that I last saw h~~er~~ alive on 9 Apr 1947.

Immediate cause of death	Duration
Chemical Peritonitis	
Due to Perforated Gall Bladder	
following Acute Hydrops	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 9 Apr 47

Major findings of operation: Same

of autopsy: None performed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature P.B. Baum M.D.

Address Univ. Hosp Date signed 9 Apr 47.

G50571

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Convent of Good Shepherd Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 76 yrs. 7 mos. 1 da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME Sister Magdalen of St Stanislaus Lynch (Mary)

(a) Residence: No. Mt. and Hollins Sts. St., 19-4 Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

4. Color or Race White

5. Single, Married, Widowed, or Divorced (write the word) Single

6a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) June 12, 1864

7. AGE 82 Years 9 Months 28 Days 27 If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Pennington (State or country) Md.

FATHER

13. NAME Louis Lynch

14. BIRTHPLACE (city or town) Not known (State or country)

MOTHER

15. MAIDEN NAME Mc Dougald

16. BIRTHPLACE (city or town) Not known (State or country)

17. INFORMANT Convent of Good Shepherd Mount Hollins. (Address)

18. BURIAL, CREMATION, OR REMOVAL Place Mt Olivet Cemetery Date 19

19. UNDERTAKER Joseph Bokey Sons (Address) 1 S Pulaski

20. FILED APR 11 1947 19 [illegible]

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Apr. 9 1947

22. I HEREBY CERTIFY, That I attended deceased from June 1943 to Apr 9 1947

I last saw her alive on Apr 8 1947. Death is said to have occurred on the date stated above, at m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Coronary Occlusion	
Other contributory causes of importance:	
Chronic Myocarditis	2yrs

Name of operation — Date of

What test confirmed diagnosis? — Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? — Date of injury 19

Where did injury occur? — (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) Jos A Strauss M. D.

(Address) 1800 N Charles St

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G50572

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

G50572
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians; please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15da
(e) Length of stay in Baltimore (yrs., mos., or days) 47yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5212 Tramore Rd #14
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Boston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	White	married

6 (b) Name of husband or wife Charles D. Boston
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1870

8. AGE: Years	Months	Days	If less than one day
76 77	10	27	hr. min.

9. Birthplace Crisfield Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Moses Ward
13. Birthplace Crisfield, Md.

MOTHER
14. Maiden Name
15. Birthplace Crisfield

16 (a) Informant Hospital Record
(b) Address

17 (a) Burial (b) Date thereof April 12 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baptist Cem.
Location Pocomoke City, Md.

18 (a) Funeral director Howard D. Boyington
(b) Address Crisfield, Md.

(a) Date rec'd by (Registrar) (b) Registrar

APR 11 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-9 1947, at 11 00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-25 1947 to 4-9 1947 and that I last saw h 4 alive on 4-9 1947.

Immediate cause of death
resp. failure — Duration
Due to cerebral hemorrhage arteriosclerosis
Due to diabetes mellitus
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 4-7-47
Major findings of operation: amputation left leg above knee for gangrene
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James J. Gerlach
Address Mercy Hosp. Date signed 4-7-47

X

G50573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 93

G50573 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1403 E. Lafayette Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 1 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1403 E. Lafayette Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dora E. Staples

3 (b) If veteran, name war: W

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife James R. Staples
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 16, 1870

8. AGE: Years	Months	Days	If less than one day
76	5	23	hr. min.

9. Birthplace Portsmouth, Virginia
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Andrew Schultz
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Elizabeth Casey
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Wilmer V. O'Brien
(b) Address 1403 E. Lafayette Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) Date received by registrar APR 11 1947 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9, 1947 at 11:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 9 1947 to April 9 1947 and that I last saw her alive on April 9 1947.

Immediate cause of death	Duration
Uraemia Nephritis	7
Due to Senility -	7
Due to Cerebral Hemorrhage	7 days
Other Conditions Hypostatic Pneumonia	7 days.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel E. Bogorad
Address 1905 W. Balt. St. Date signed 4/10/47

G50571 Draft would like Certificate 30 D

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G50574

PLEASE WRITE PLAINLY, with ink. CAREFULLY answer all questions. Be sure to give the causes of death clearly and legibly. correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: South Baltimore Hosp ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) dea
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 718 S. Charles St
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME James Marshall ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1914

8. AGE: Years	Months	Days	If less than one day
33			....hr. ....min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation laborer

11. Industry or business

FATHER 12. Name Thomas E. Marshall

13. Birthplace A.C.

MOTHER 14. Maiden Name Amil Madden

15. Birthplace Winterburn

16 (a) Informant Thomas Marshall

(b) Address Cambridge, Md.

17 (a) Burial (b) Date thereof April 14 7
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cemetery
Location Cambridge Md

18 (a) Funeral director Lewis W. Bowman

(b) Address Cambridge Md

APR 11 1947 (b) Huntingtown Williams MD
(Date rec'd by local Registrar) (Signature of local Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9th 1947, at 11 30 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hemorrhage

Due to Rupture of Aortic Aneurysm into the esophagus

Other Conditions Syphilitic Aortitis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury..... at..... M.

(b) Where did injury occur?.....

(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....

(d) Means of injury.....

23. Signature Earl L Royer M.D.
Medical Examiner.

Date signed.....

X

0575

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G50575
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Provident Hosp
(c) Hospital or institution: 1514 Division St
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County Halifax
(c) City or town Scottsburg (If outside city or town limits, write RURAL and give town)
(d) Street No. P. O. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charity Coleman

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	Col	Married

6 (b) Name of husband or wife Algier
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-12-1889

8. AGE: Years	Months	Days	If less than one day
58	1	29	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Home Wife
11. Industry or business

FATHER 12. Name Richmond Fleming
13. Birthplace Va

MOTHER 14. Maiden Name Vicee
15. Birthplace Va

16 (a) Informant Minnie Holmes
(b) Address 1322 W. Lanvale St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 4-12-47 (month) (day) (year)
(c) Cemetery or crematory Pine Grove Cem
Location Amherst Virginia

18 (a) Funeral director William A Johnson
(b) Address 916 Pennsylvania Ave

19 (a) APR 1 1947 (Date rec'd by registrar) (b) Huntington W. Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1947, at 8:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-18-1947 to 4-9-1947, and that I last saw h[illegible] alive on 4-9 1947.

Immediate cause of death	Duration
Pneumonia Rt Lung.	4 wks.
Due to Coronary Occl.	
Due to	
Other Conditions Hypertension Heart Disease (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richmond Virginia M. D.
Address 2743 Madison Date signed 4-10-47

97

G50576

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G50576 Registered No.

CM. 86668

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 1 11
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1930 N. Franklin St. (Inf.) (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME Harry Wright

3 (b) If veteran, name war	3 (c) Social Security Account No.
***	NO

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Wife (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 28-1862

8. AGE: Years	Months	Days	If less than one day
84	11	13	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Levin Wright
13. Birthplace Md.

MOTHER
14. Maiden Name Helen FrancesRose
15. Birthplace Conn.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave. (Record)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/12/47 (month) (day) (year)
(c) Cemetery or crematory McKendree Church Cem.
Location Howard County

18 (a) Funeral director George. W. Little
(b) Address 2700 Edmondson Ave.

APR 11 1947 (Date rec'd by Registrar) (b) Signature of Registrar

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9-47 19 47, at 8.15a M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-28-44 19 44, to April 9 19 47, and that I last saw h im alive on April 9 1947

Immediate cause of death	Duration
Carcinoma of colon	7
Due to	
Due to	
Other Conditions Generalized Arteriosclerosis	7

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.
Address Baltimore City Hosp. Date signed 4-9-47

X

50577.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1314

G50577 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2016 W. Saratoga St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2016 W. Saratoga St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James A Cole

3 (b) If veteran, name war

3 (c) Social Security Account No. 150

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Violet M
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1, 1874

8. AGE: Years	Months	Days	If less than one day
73	3	8	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Retired

FATHER
12. Name James Cole
13. Birthplace Md

MOTHER
14. Maiden Name Ida Harris
15. Birthplace Md

16 (a) Informant Mrs Violet M Cole
(b) Address 2016 W. Saratoga St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 11 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3401 Frederick Ave
18 (a) Funeral director Henry H Withe
(b) Address 4101 Edmondson Ave

19 (a) APR 11 1947 (b) [illegible] Maryland

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1947, at 6A M

21. I certify that death occurred on the date above stated, that I attended deceased from 3-10 1946 to 4-9 1947, and that I last saw h[illegible] alive on 4-9 1947.

Immediate cause of death	Duration
Acute Cardiac Failure	
Due to Cardio Vascular Renal Disease	24 yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Joseph L Lawrence M. D.
Address 1719 Washington Blvd Date signed 4/10/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be answered. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

50578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G50578 Registered No. 3698

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information known must be entered. Where the exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1729 Edmondson Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Over 25 years
(e) Length of stay in Baltimore (yrs., mos., or days) Unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1729 Edmondson Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emma Mason.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife George Mason

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 28, 1886

8. AGE: Years	Months	Days	If less than one day
61	60	-	11 hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name Wm. Henry Watson
13. Birthplace Virginia

MOTHER
14. Maiden Name Annie C. Wilson
15. Birthplace Calvert Co. Md.

16 (a) Informant Louis Mays
(b) Address 1729 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-12-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) Date received APR 14 1947 Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-8- 1947, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-6- 1947, to 4-8- 1947 and that I last saw him alive on 4-7- 1947

Immediate cause of death Myocarditis — Duration Unknown

Due to

Due to Arteriosclerosis

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank A. Saunders M. D.
Address 1b 29 N. Stricker St. Date signed 4-9-47

X

G50579

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G50579

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 514 N. Pine
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 514 N. Pine (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Bates

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife John Bates

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 5, 1883

8. AGE: Years 63 | Months 7 | Days 3 | If less than one day ____ hr. ____ min.

9. Birthplace Dinwiddie Co., Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name David Macklin
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Macklin
15. Birthplace Virginia

16 (a) Informant Mrs. James Bates
(b) Address 219 N. Pine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-11-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

APR 11 1947 (Date rec'd by registrar) Washington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/8/1947, at 9:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis, M.D. Medical Examiner.
Date signed 4/9/47

X

G50580

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G50580 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address – Wokeland & Rayner Ave
(c) Hospital or institution: West Baltimore Gen'l Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Lansdowne (If outside city or town limits, write RURAL and give town)
(d) Street No. 2803 Hammonds Ferry Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry D. Cover

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Rose T. Cover (nee Kress) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 14, 1898

8. AGE: Years	Months	Days	If less than one day
48	7	25	hr. min.

9. Birthplace Carroll Co., Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business Gas & Electric Co.

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Alice Zepp
15. Birthplace Carroll Co., Md.

16 (a) Informant Mrs. Rose T. Cover
(b) Address 2803 Hammonds Ferry Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/12/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (Date received) APR 11 1947 (Registrar's signature) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-9 1947, at 10:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-6-1947 to 4-9-1947 and that I last saw h/ alive on 4-9-1947

Immediate cause of death	Duration
Coronary	
Due to Thrombosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benjamin Perlmutter, M.D.
Address West Balto Gen'l Hosp Date signed 4-10-47

50581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G50581
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 919 N Monroe St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 919 N Monroe St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie H. Bossom

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Harry Bossom

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jun 16 1889

8. AGE: Years 89 Months 2 Days 22 If less than one day hr. 57 min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER
12. Name Richard Hutchins
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Bradenbaugh
15. Birthplace Maryland

16 (a) Informant Harry Bossom
(b) Address 919 N. Monroe St.

17 (a) Burial (b) Date thereof 4/9/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.

18 (a) Funeral director Manuel Cooke Sykes
(b) Address 1600 W. North Ave

19 (a) APR 11 1947 (b) Filed by Huntington Williams MD
VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8th 1947, at 2 15 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Sclerosis - Cardio-Vascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wilhams G Pickard M.D.
Medical Examiner.
Date signed 7 Apr 47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50582

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G50582 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 7805 Fairgreen Road. Dundalk. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK E, CARMAN

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife late Clara M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 8, 1893

8. AGE: Years 53 | Months 4 | Days 2 | If less than one day ____ hr. ____ min.

9. Birthplace New Jersey. (Town, county, and state)

10. Usual Occupation Guard

11. Industry or business Beth Steel Company

FATHER
12. Name Frank Carman
13. Birthplace New Jersey.

MOTHER
14. Maiden Name Unknown
15. Birthplace New Jersey.

16 (a) Informant Mr Geo L. Carman
(b) Address 870 W. Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/47 (month) (day) (year)
(c) Cemetery or crematory Loraine Park Cem
Location 5602 Wagners Road

18 (a) Funeral director John J Conway & Son
(b) Address 901-03 Hollins St.

APR 11 1947 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10, 1947, at 9.45 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pulmonary Embolus

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-9-47 at ? M.
(b) Where did injury occur? 7805 Fairgreen Rd. Dundalk
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Struck parked auto

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 4-11-47

VS 181

Motor cycle - X

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G50583

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 E

G50583
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2900 Bowers Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2900 Bowers Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Julian Tapp Rowe

3 (b) If veteran, name war

3 (c) Social Security Account No. 202-03-6053-A

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Anna B. Rowe
6 (c) If alive, give age 68 yrs

7. Birth date of deceased (mo., day, yr.) July 5, 1870

8. AGE: Years	Months	Days	If less than one day
76	9 6	5	hr. min.

9. Birthplace Philadelphia, Pa.
(Town, county, and state)
10. Usual Occupation Seedsman
11. Industry or business Seed

FATHER
12. Name Miflin W. Rowe
13. Birthplace Philadelphia, Pa.

MOTHER
14. Maiden Name Deborah Tapp
15. Birthplace Devonshire, England

16 (a) Informant Mrs. Anna B. Rowe
(b) Address 2900 Bowers Ave.

17 (a) Burial (b) Date thereof Apr. 12, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arlington Cemetery
Location Druid Hill, Pa.

18 (a) Funeral director Wells Lawrason
(b) Address 4510 Liberty Heights Ave.

19 APR 11 1947 (b) Huntington Williams, M.D.
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1947, at 5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 9 1946, to April 10 1947, and that I last saw h. in alive on April 8 1947.

Immediate cause of death	Duration
1 Carcinomatosis of Colon	6 months
Due to	
Due to	
Other Conditions Tertiary Syphilis	- 5 yrs.

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Earl L. Chambers M. D.
Address 4108 Liberty Hgts Ave. Date signed

X

G50581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G50581 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd St. & Guilford Ave.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 7
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3615 Woodbine Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME BENJAMIN V. PAINE

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Alice Paine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1865

8. AGE: Years	Months	Days	If less than one day
81	8	29	hr. min.

9. Birthplace Edinburg, Indiana (Town, county, and state)

10. Usual Occupation ~~Farmer~~ Retired Pattern Maker
11. Industry or business

FATHER
12. Name Luther Paine
13. Birthplace Ohio

MOTHER
14. Maiden Name Rebecca Van de Vere
15. Birthplace Ohio

16 (a) Informant Hospital Records
(b) Address 33rd St. & Guilford ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 12, 1947 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Miller & Layman
(b) Address 4510 Liberty Heights Ave.

19 APR 11 1947 (Date received by Local Registrar) (b) Huntington Williams M.D. (Signature of Local Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9, 1947, at 7:33 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 4, 1947 to April 9, 1947 and that I last saw him alive on April 9, 1947.

	Duration
Immediate cause of death Congestive cardiac failure	?
Due to Arteriosclerotic heart disease	?
Due to	
Other Conditions Malnutrition	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 4/9/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50585

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G50585 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given if possible. Every question must be answered, or a satisfactory reason given for failure to do so. Accuracy in stating the causes of death clearly and legibly. correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland N. Carlton St
(b) Street address 615
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 615 Carlton St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Marie A. Miles

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband ~~or wife~~: Elisha Miles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 21-1905

8. AGE: Years 41 | Months 5 | Days 19 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name George Williams
13. Birthplace Va

MOTHER 14. Maiden Name Lena Gales
15. Birthplace Va

16 (a) Informant Elisha Miles
(b) Address 615 Carlton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-12-47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co.

18 (a) Funeral director Rayner Sanders
(b) Address 1112 E Preston St

APR 11 1947 Registrar Washington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 9 - 1947, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1946 to Apr 9 1947 and that I last saw her alive on Apr 9 1947

Immediate cause of death Carcinoma Stomach — Duration 8 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 2829 Jacques St. Date signed Apr 10 1947

VS 150

X

C50586

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. C50586

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the e the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1314 HOLLINS ST.
(c) Hospital or institution: ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓ 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1314 Hollins St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME ROZALIA MALDUTIS

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Widowed

6 (b) Name of husband or wife BENEDICT MALDUTIS
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-24-1871

8. AGE: Years	Months	Days	If less than one day
75 76	11	8 14	hr. min.

9. Birthplace LITHUANIA (Town, county, and state)
10. Usual Occupation RETIRED
11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. KRIAUSKAS
(b) Address N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-12-1 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Charles P. Kriauskas
(b) Address 703 McHENRY ST.

APR 11 1947 (Date rec'd by Registrar) (b) [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-8-47 19 , at 6 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-10-47 19 to 4-8 19 47 and that I last saw h[illegible] alive on 4-8 19 47

Immediate cause of death Acute Cardiac Failure — Duration 1da
Due to Cerebro Vascular Renal Disease — 5yr
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dougl[illegible] Lawrason M. D.
Address 6 Graham Pl Date signed 4-10-47

G50587

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

Registered No. G50587

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 Caroline St.
(c) Hospital or institution:
St Josephs Hospital · 91
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 51

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (18)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1604 E 30th St
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs. Elizabeth M Greeley.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 17 - 1887

8. AGE: Years 59 | Months 4 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name [illegible] Rojo

13. Birthplace Md.

MOTHER 14. Maiden Name Emma Heintz

15. Birthplace Md.

16 (a) Informant William J. Greeley

(b) Address 1604 - 30th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/47 (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location Belair Rd

18 (a) Funeral director John A. Ingram

(b) Address Gov E. Baltimore

19 (a) APR 11 1947 (Date rec'd by registrar) [illegible] Williams, M.D. Address

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1947, at 7.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 19 1947 to April 10 1947, and that I last saw her alive on April 10 1947.

Immediate cause of death Cardiac Deficiency, failure — Duration

Due to Cerebral Embolism

Due to detached vegetation from Aortic Valve

Other Conditions Subacute Bacterial endocarditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Aortic valvulitis

of autopsy: disease & vegetation

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature John B Wells M.D.

M. D. Address [illegible] Date signed 4-10-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Type or information should be given by person most familiar with facts. Give full name of deceased, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G50588 Ctf # 70582

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G50588

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given. Use black ink. Do not use pencil. Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 weeks

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1605 Union Ave. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Margaret W. Gray

3 (b) If veteran, name war /
3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 10, 1947

8. AGE: Years 0 | Months 2 | Days 0 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name William T. Gray.
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary E. Polick
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address 33rd & Calvert St. Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 12/47 (month) (day) (year)
(c) Cemetery or crematory St. Marys Penna
Location.....

18 (a) Funeral director Chas P. Powell
(b) Address 2427 Edmondson Ave

APR 11 1947 (Date rec'd by Registrar) (b) Baltimore, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1947, at 1 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 4 1947, to April 10 1947, and that I last saw h[illegible] alive on April 10 1947.

Immediate cause of death: Respiratory obstruction — Duration: 4 hrs.
Due to: Broncho-pneumonia — 6 days.
Due to..... — over
Other Conditions: Cardiac Decompensation — 3 days.
(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature Ernest V. deMoss, M.D. M. D.
Address Union Memorial Hosp. Date signed 4-10-47

107

G50589
AB-109657

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1947

Registered No. G50589

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered; suppose correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2556 Oswego Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Patterson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 27- 1867

8. AGE: Years	Months	Days	If less than one day
79	11	12	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Samuel W. Patterson
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Gillen
15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 12, 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Frederick A. Dole
(b) Address 1200 W. Lombard St

19 (Signature) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9- 1947 at 3.25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-4- 1947 to 4-9- 1947 and that I last saw h- alive on 4-9- 1947

Immediate cause of death: Bronchopneumonia — Duration: 2 days

Due to:

Due to: Fracture neck of right femur — 6 days

Other Conditions: Hypertensive cardiovascular disease
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 15 13
(a) Accident, suicide, or homicide accident
(b) Date of occurrence April 3, 1947 at 3:00 P.M.
(c) Where did injury occur? Baltimore, Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? no
(e) Means of injury Fall on steps (inside)

23. Signature R. L. Gibbs
Address Baltimore City Hosp. Date signed 4/9/47

VS 150 To be approved by the Medical Examiner For C.W.S. Hedford by Howard L. Mueller M.D.

650590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

650590 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1316 William St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1316 William St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William R. Williams

3 (b) If veteran, name war
3 (c) Social Security Account No. 211-05-7397

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Eleanora Dawson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/4/1890

8. AGE: Years 56 | Months 10 | Days 27 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Boat builder
11. Industry or business

FATHER 12. Name Wm. A. Williams
13. Birthplace Balto Co Md

MOTHER 14. Maiden Name Mary J. Downs
15. Birthplace Balto City Md

16 (a) Informant Mrs R. R. Williams
(b) Address 1316 William St

17 (a) Burial, cremation, or removal Balto (b) Date thereof 4/12/47 (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Frederick Road

18 (a) Funeral director Leigh Hayes
(b) Address 1316 Light St.

19 (a) APR 11 1947 Huddington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1947, at M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 2 1943 to 4/9 1947.
I last saw him alive on 4/9 1947.

Immediate cause of death Myocarditis
Duration 6 mo
Due to Hemiplegia 2 yrs.
Due to Arteriosclerosis 2 yrs.
Other Conditions Hypertension Entire 8 yrs.
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature O J Mello MD
Address 1429 Mulberry St Date signed M.D. 4/10/47

VS 150

G50591

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93c

Registered No. G50591

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4409 Frederick avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4409 Frederick avenue
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME BROTHER MAURICE C.F.X. (Vincent J. McDonnell)

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none
4. Sex: Male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: --
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 21, 1862
8. AGE: Years 85 | Months 2 | Days 19 | If less than one day ... hr. ... min.
9. Birthplace Phila. Penna. (Town, county, and state)
10. Usual Occupation Xaverian Brother
11. Industry or business

FATHER
12. Name Terence McDonnell
13. Birthplace Unknown

MOTHER
14. Maiden Name Mary Wilcox
15. Birthplace Unknown

16 (a) Informant Xaverian Brothers
(b) Address 4409 Frederick avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/12/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas J Evans Son Inc
(b) Address 111 N. Mt. Royal Ave
APR 11 1947 (b)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 19 47 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to April 10 1947. and that I last saw him alive on April 9 19 47.

Immediate cause of death Pulmonary Oedema.

Due to Hypostatic.

Due to Hypostasis.

Other Conditions Asthenia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Norbert F. Welsh M. D.
Address 215 E Wilkens Ave Date signed 4/10/47

G50592

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45a

Registered No. G50592

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered, even though it appears unimportant. Physicians: please write the correct age in especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 346 Camel Street
(c) Hospital or institution: 11

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County None
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 346 Camel Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Holmes

3 (b) If veteran, name war: None
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25, 1899

8. AGE: Years 48 | Months 2 | Days 16 | If less than one day ... hr. ... min.

9. Birthplace Charleston, S. C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business American Paving Co.

FATHER
12. Name Benjamin Holmes
13. Birthplace S. C.

MOTHER
14. Maiden Name Rebecca Holmes
15. Birthplace S.C.

16 (a) Informant Mary Kiah
(b) Address 346 Camel Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/47 (month) (day) (year)
(c) Cemetery or crematory
Location Charleston, South Carolina

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Avenue

19 APR 11 1947 (Date received by Registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11, 1947 at 4:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/10/47 to 4/11/47, and that I last saw h[illegible] alive on 4/11/47 to [illegible]

Immediate cause of death [illegible] of Life months — Duration [illegible] Months
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. R. Klein M. D.
Address 924 Mad. Ave. Date signed 4/11/47

VS 180

X

50593 BALTIMORE CITY HEALTH DEPARTMENT G50593

CHK- BC# G-74815 CERTIFICATE OF DEATH ✓ 160a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State New York (b) County
(c) City or town Buffalo
(If outside city or town limits, write RURAL and give town)
(d) Street No. 713 N. Ferry Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Carter--Ruth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 29-1947

8. AGE: Years	Months	Days	If less than one day
		5	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Carl Edward Carter
13. Birthplace New York

MOTHER
14. Maiden Name Ruth Farley
15. Birthplace Massachusetts

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Cremated (b) Date thereof 4-10-47
(cremation,) (month) (day) (year)
(c) Name of crematory Baltimore City Hospitals
Location 4940 Eastern Ave (Records)

18 (a) Funeral director
(b) Address

19 (c) APR 11 1947 Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1947, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 29 1947 to Apr. 4 1947, and that I last saw h. alive on Apr. 4 1947.

Immediate cause of death	Duration
Cerebral Injury	5 days
Anoxemia	5 days
Due to	
Due to	
Other Conditions Prematurity wt 1 lb 15 oz.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Julian P. Phippin M. D.
Address Balt City Hosp Date signed 8 Apr 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

VS 150

G50594

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G50594

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be answered. Where there is no entry, write NONE. Be sure to write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Be sure that the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 30 N. Bentalou Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 30 N. Bentalou Street
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA M. NEUENDORFF

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Richard C.
6 (c) If alive, give age D. years

7. Birth date of deceased (mo., day, yr.) July 10, 1864

8. AGE: Years	Months	Days	If less than one day
82	8	29	****hr. *****min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Max Schwender
13. Birthplace Germany

MOTHER
14. Maiden Name unknown
15. Birthplace Germany

16 (a) Informant Richard Neuendorff
(b) Address 30 N. Bentalou Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 12/47 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore Maryland

18 (a) Funeral director P. B. Gilbert & Son
(b) Address 1300 Eutaw Place...17

APR 11 1947 (Date received by Registrar) (b) [signature] M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 9 1947, at 10:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to Apr 9 1947 and that I last saw her alive on April 9 1947.

Immediate cause of death	Duration
Hemyeleph	1 day
Due to Cerebral Hemorrhage	2 days
Due to Arteriosclerosis	
Other Conditions ~	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: ~
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 876 Washington Blvd. Date signed 4/10/47

G50595

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G50595

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be answered. Where exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 317 N. Payson St
(c) Hospital or institution: No

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 317 N. Payson St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Gronemyer

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) ~~Single~~, ~~married~~, widowed, or divorced. Widowed

6 (b) Name of husband or wife Caroline
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 23-1859

8. AGE: Years 87 | Months 7 | Days 12 | If less than one day hr. — min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Retired
11. Industry or business Cigar making

FATHER
12. Name Not known
13. Birthplace Germany

MOTHER
14. Maiden Name Not Known
15. Birthplace Germany

16 (a) Informant Mrs. Ella Gedlich
(b) Address 317 N. Payson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/47 (month) (day) (year)
(c) Cemetery or crematory Western Cem
Location

18 (a) Funeral director Chas P Powell
(b) Address 2427 Eutaw Pl Baltimore, Md

APR 11 1947
(Date received by local registrar)

V8 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1947 at 3:5 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 1 1947 to Apr 10 1947, and that I last saw h[illegible] alive on Apr 10 1947

Immediate cause of death Cerebral edema — Duration

Due to Coronary Thrombosis — Duration

Due to Uremia — Duration

Other Conditions Arteriosclerosis — Duration

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Kadan M. D.
Address 2306 Eutaw Pl Date signed 4-11-47

050596

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 146B

Registered No. 050596

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 125 S. Catherine St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 125 S. Catherine St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Dogariu

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Late Emilie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 5, 1882.

8. AGE: Years	Months	Days	If less than one day
65	2	4 5	hr. min.

9. Birthplace Hungary (Town, county, and state)
10. Usual Occupation Retired Fireman
11. Industry or business B. & O. R. R.

FATHER
12. Name Dogariu
13. Birthplace Hungary

MOTHER
14. Maiden Name Unknown
15. Birthplace Hungary

16 (a) Informant Mrs. Barbara Peters
(b) Address 2563 W. Fairmount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 12/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd.

18 (a) Funeral director Harry A. Kutzler
(b) Address 4101 Edmondson Ave.

19 (a) APR 11 1947 [illegible] M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10/47. 19 at M

21. I certify that death occurred on the date above stated that I attended deceased from 4/7 19 47 to 4/9 19 47 and that I last saw Catherine on 4/9 19 47

Immediate cause of death — Duration

Carcinoma of Stomach — 6 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. Carlin M.D.
Address 2145 W. Balto. St. Date signed 4/10/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Examine the certificate after it is written and correct any error or omission. Be sure to write the causes of death clearly and legibly. Do not use abbreviations or symbols. Make entries for all items, or write none, or insert "unknown" where necessary to complete the record. Do not leave blanks except for items that do not apply. Be sure the date of death is complete and correct. Be sure the age is correct. Physicians: please write the causes of death clearly and legibly. Be especially important.

VS 150

X

G50597

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

G50597 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street City
(c) Hospital or institution:
Little Sister of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Edward Sullivan

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 30, 1875

8. AGE: Years	Months	Days	If less than one day
72	2	11	hr. min.

9. Birthplace Boston Mass.
(Town, county, and state)
10. Usual Occupation Labourer
11. Industry or business

FATHER
12. Name Daniel Sullivan
13. Birthplace Ireland

MOTHER
14. Maiden Name Hannah Green
15. Birthplace Ireland

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Baltimore

18 (a) Funeral director Geo Kane & Sons
(b) Address 701 East Fayette St

19 (a) APR 11 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 — 1947, at 5-30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Apl-1-- 1947, to April 10 1947, and that I last saw him alive on April 9— 1947.

Immediate cause of death	Duration
Edema Lungs	3 days
Due to Mitral Stenosis	10 yrs
Due to	
Other Conditions Arteriosclerosis	10 yrs

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E Gill Hall, M. D.
Address 1631 E. North Av Date signed 4/11/47

VS 3

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

C50598

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C50598

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 612 S. Oldham St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander Giovanis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
72			hr. min.

9. Birthplace Greece (Town, county, and state)

10. Usual Occupation Confectioner

11. Industry or business

FATHER
12. Name Peter Giovanis
13. Birthplace Greece

MOTHER
14. Maiden Name Unknown
15. Birthplace Greece

16 (a) Informant John Giovanis
(b) Address La Salle Apt 1

17 (a) Interment (b) Date thereof 4-11-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Evergreen
Location Evergreen Park Dr

18 (a) Funeral director Milhorn & Taylor
(b) Address 1319 E. Fort Ave

19 APR 11 1947 (Date received by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1947, at 11:05 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiac Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Paul L. Reese M.D.
Medical Examiner
Date signed 4-10-47

VS 181

C50599

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. C50599

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 927 N. Calvert St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 927 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Charles E. Gilliam

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Married

6 (b) Name of husband or wife Millie Stover
6 (c) If alive, give age 84 years

7. Birth date of deceased (mo., day, yr.) Oct. 10. 1864

8. AGE: Years	Months	Days	If less than one day
82	6	1	hr. min.

9. Birthplace Frederick City, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Blacksmith

FATHER
12. Name Phillip Gilliam
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Hooper
15. Birthplace Md.

16 (a) Informant Mrs. Chas. Gilliam
(b) Address 927 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 14 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Md.

18 (a) Funeral director Powell & Hartzler
(b) Address Hyattstown, Md.

19 (a) APR 11 1947 (Date rec'd by Registrar) [signature] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 April 1947, at 3:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 29 Mar. 1947, to 11 April 1947, and that I last saw him alive on 11 April 1947.

Immediate cause of death Generalized arteriosclerosis — Duration years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis E. Weck, M. D.
Address 920 St. Paul Date signed 11 Apr. '47

G.0500

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G50500

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be answered. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette and Calhoun
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 33
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5604 Gorsuch Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Perry S. WHITE
3 (b) If veteran, name war
3 (c) Social Security Account No. 217-14-9638

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Lina White
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 10 1872

8. AGE: Years	Months	Days	If less than one day
74	5	0	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Seaman
11. Industry or business

FATHER
12. Name Jacob WHITE
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine TULL
15. Birthplace Md.

16 (a) Informant Lina White
(b) Address 5604 Gorsuch Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/47 (month) (day) (year)
(c) Cemetery or crematory Morland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul st.

19 (a) APR 12 1947 (Date received by Registrar) (b) Huntington Millington, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 April 1947, at 4 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8 Mar 1947, to 10 Apr 1947, and that I last saw him alive on 10 Apr 1947

Immediate cause of death	Duration
Bronchopneumonia	25 days
Due to Cardiac decompensation	
Due to	
Other Conditions Arteriosclerotic heart disease (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stanley B. Klyanowicz, M.D.
Address Franklin Sq. Hosp. Date signed 4/10/47

107

G50601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G50601 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered, or the certificate will be returned. Do not use abbreviations. If the exact date of any fact stated is unknown, give the best estimate possible. Physicians: please write the causes of death clearly and legibly. Underlining is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 511 Walker Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 511 Walker Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen P. Jensen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John Jensen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1876

8. AGE: Years 70 | Months 4 | Days 14 | If less than one day ..... hr. ..... min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business: Own Home

FATHER
12. Name: Charles A. Schaun
13. Birthplace: Germany

MOTHER
14. Maiden Name: Maria A. Salchow
15. Birthplace: Germany

16 (a) Informant: Mrs. Andrew Tempel
(b) Address: 703 Gittings Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/47 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore, Maryland

18 (a) Funeral director: Wm. Cook, Inc.
(b) Address: 1217 St. Paul Street

19 (a) APR 12 1947 (Date rec'd by registrar) Huntingtown, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1947, at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 27 1946 to April 11 1947, and that I last saw h[illegible] alive on April 11 1947.

Immediate cause of death: Hypertension — Cardiovascular Renal Disease — Duration: 5 yrs

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: A. L. Chartant M. D.,
Address 6710 York Rd. Date signed April 11, 47

X

G50602

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G50602

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use no abbreviations. Do not write above or below the lines. Be sure to write the causes of death clearly and legibly. Give the correct age if it is especially important. Physicians: please write your orders plainly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital ~~or institution~~: University Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 614 Lenox St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs. Elma Stamoules

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Pete Stamoules

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5th 1877

8. AGE: Years 69 | Months 9 | Days 6 | If less than one day hr. min.

9. Birthplace Louisa Va.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER
12. Name Garrett C. McGehee
13. Birthplace Va.

MOTHER
14. Maiden Name Georgia Anna Harrison
15. Birthplace Va.

16 (a) Informant Marion L. East
(b) Address 4706 Walther Blvd

17 (a) Burial (b) Date thereof 4/15/42
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Moreland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) APR 2 1942 (b)
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-11-1942, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-5-1942 to 4-11-1942, and that I last saw h~~er~~ alive on 4-11-1942

Immediate cause of death	Duration
Acute Pulmonary Edema	
Due to Arteriosclerosis, CVD	
Due to Generalized arterial	
Other Conditions Left hemiplegia. Pelvic cancer??	years

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]
Address Univ. Hosp. Date signed 4-11-42 M. D.

X

G50603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V13B

Registered No. G50603

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Give correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 913 RIDGELY ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 913 RIDGELY ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** FRANK J. MOYER

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-05-8159

4. Sex MALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced. WIDOWER

6 (b) Name of husband or wife FANNIE MOYER

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) DEC. 4 - 1889

8. AGE: Years 57 | Months 4 | Days 6 | If less than one day hr. min.

9. Birthplace BALTIMORE (Town, county, and state)

10. Usual Occupation GLASS PACKER.

11. Industry or business SWINDELL BROS

FATHER
12. Name GEORGE MOYER
13. Birthplace BALTIMORE MD

MOTHER
14. Maiden Name MARGT STRECKFUSS
15. Birthplace BALTIMORE MD

16 (a) Informant EVELYN BRESLAU
(b) Address 913 RIDGELY ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4-14-47 (month) (day) (year)

(c) Cemetery or crematory LOUDON PARK.
Location BALTO MD

18 (a) Funeral director Bernard C Hank
(b) Address 121 E West St

19 APR 12 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1947, at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1943 to 10 Apr 1947 and that I last saw him alive on 10 Apr 1947.

Immediate cause of death PULMONARY TUBERCULOSIS — Duration 3 yrs?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward J Milan, M.D.
Address 682 Wilson Line Signed 11 Apr 47

VS 150

G50604

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G50604

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Worcester
(c) City or town Snow Hill
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN MOORE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Elmer Moore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years	Months	Days	If less than one day
61			hr. min.

9. Birthplace Worcester Co Md
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Cement

FATHER
12. Name John P Moore Sr
13. Birthplace Md

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof April 13/47 (month) (day) (year)

(c) Cemetery or crematory Presbyterian Cem
Location Snow Hill Md

18 (a) Funeral director Clay E Dennis
(b) Address Snow Hill

19 (a) APR 12 1947 (Registrar's signature) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11, 1947, at 10.55 A M

21. I certify that I took charge of the remains described above, held an insp. & inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 4-11-47

correct age is especially important. Physicians: please write

VS 151

X

G50605

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G50605

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry must be made for each item. Do not write the causes of death clearly and legibly. correct age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 616 N Highland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore 19
(If outside city or town limits, write RURAL and give town)
(d) Street No. 616 N Highland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Duke

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-03-3815

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Sophia Duke
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Aug 8 1879

8. AGE: Years	Months	Days	If less than one day
67	8	2	____ hr. ____ min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Continental Can Co
11. Industry or business

FATHER
12. Name Frederick Duke
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Baumeier
15. Birthplace Germany

16 (a) Informant Sophia Dyke
(b) Address 616 N Highland Ave

17 (a) Burial (b) Date thereof April 14.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem
Location City

18 (a) Funeral director Hillis & Funeral Home
(b) Address 2005 Orleans St

19 APR 12 1941 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1941, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/12 1940, to 4/10 1941.
and that I last saw h[illegible]live on 4/10 1941.

Immediate cause of death	Duration
Acute suburban Cardiac	1
Failure and Anuria	[illegible]
Due to	[illegible]
	[illegible]
Other Conditions Senility Thrombosis	6 mos.
(Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Peter P. Jakovsky M. D.
Address 5939 Belair Rd Date signed 4/11/41

G50606

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1931

Registered No. G50606

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given and every question answered. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Garrison Blvd.
(c) Hospital or institution: Mrs. Prout's Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3600 Greenmount Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Frances Rasin Roberts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: George Clinton Roberts

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
about 72			hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Joseph Osborne Rasin
13. Birthplace Md.

MOTHER
14. Maiden Name Florence Rasin
15. Birthplace Md.

16 (a) Informant Mrs. Isabelle I. Rowe
(b) Address 3301 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/12/47 (month) (day) (year)
(c) Cemetery Greenmount
Location Greenmount Ave. & Oliver St.

18 (a) Funeral director John O. Mitchell & Son, Inc.
(b) Address 1900 Eutaw Place

19 APR 12 1947 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1947, at 8 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 20 1947, to April 10 1947, and that I last saw h.er alive on April 10 1947

Immediate cause of death	Duration
Pulmonary Edema	7 hours
Due to Arteriosclerotic Heart Disease	?
Due to	
Other Conditions Coronary Occlusion	1 day

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dafner H. Gardner M. D.
Address Medical Arts Bldg. Date signed 4/12/47

G50607

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G50607

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Be sure every item is correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1523 Barclay St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1523 Barclay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Grant

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 9, 1880

8. AGE: Years 66 67 | Months 8 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Maid

11. Industry or business

FATHER 12. Name William Hollis
13. Birthplace Centerville, Md

MOTHER 14. Maiden Name Louisa Nichols
15. Birthplace Centerville, Md

16 (a) Informant Mrs. Eleanor Miller
(b) Address 1523 Barclay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-12-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Lee H. Holland
(b) Address 651 Druid Hill Ave.

19 APR 12 1947 (Date rec'd by registrar) Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1947 at 9P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1946 to April 10 1947 and that I last saw h[illegible] alive on April 10 1947

Immediate cause of death: Pulmonary Tuberculosis — Duration: 2 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 2329 Guilford Date signed April 12 1947

VS 150

G50608

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G50608 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2425 Madison Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ada Briscoe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Robert L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 19, 1889

8. AGE: Years 57 | Months 7 | Days 22 | If less than one day hr. min.

9. Birthplace Harrington, Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Stephen Addison
13. Birthplace Va

MOTHER
14. Maiden Name Harriette Holmes
15. Birthplace Harrington, Va

16 (a) Informant Robert L. Briscoe
(b) Address 2425 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-13-47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto Md

18 (a) Funeral director Wm. Chas. H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) APR 12 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10, 1947, at 10.20 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Carcinoma of breast, with widespread metastases

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D. Medical Examiner.
Date signed 4/10/47

VS 191

correct age is especially important. Physicians: please write the c

G50609

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G50609

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2225 Ivy Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Jones

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lillian
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-14-87

8. AGE: Years 59 | Months 7 | Days 27 | If less than one day hr. min.

9. Birthplace Pa (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Jefferson Jones
13. Birthplace Va

MOTHER 14. Maiden Name Louise B. Neal
15. Birthplace Va.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 14, 1947 (month) (day) (year)
(c) Cemetery or crematory Carbuta Mem. Park.
Location Baltimore, Maryland

18 (a) Funeral director J. L. Preston Limberger
(b) Address 509 N. Monroe St.

19 APR 12 1947 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1947 at 7 45 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 22 1947 to April 10 1947 and that I last saw him alive on April 10 1947

Immediate cause of death Cerebral hemorrhage — Duration 5 min

Due to Arteriosclerosis (cerebral) — Duration 2 yrs

Due to — Duration

Other Conditions Hypertension & Arteriosclerotic heart disease — Duration 10 yrs
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address [illegible] Date signed 4/10/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Be sure to write the causes of death clearly and legibly. If exact age is especially important. Physicians: please write

VS 150

G50610

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 192 B

Registered No. G50610

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure that correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3929 Ridgewood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 10
(e) Length of stay in Baltimore (yrs., mos., or days) 36

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3929 Ridgewood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Amanda Helt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Raymond H. Helt.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 12/1880

8. AGE: Years 66 Months 7 Days If less than one day hr. min.

9. Birthplace Reading Pa
(Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER 12. Name Edward Scherer

13. Birthplace Unknown

MOTHER 14. Maiden Name Amanda Scheaderl

15. Birthplace Reading Pa

16 (a) Informant Raymond H. Helt.

(b) Address 3929 Ridgewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof apl 14/1947 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Woodlawn Md

18 (a) Funeral director Harry H. Armacost

(b) Address 4704 Ridgewood Ave

19 (a) APR 12 1947 (Date received by Registrar) (b) Huntington Millspaugh, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1947, at 5.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 1939 to April 12 1947, and that I last saw h[illegible] alive on April 11th 1947.

Immediate cause of death Myocardial insufficiency, with Congestive failure. — Duration 1 month

Due to Chronic rheumatic valvular heart disease (mitral insufficiency) —

Due to Cardiac hypertrophy with hypertension —

Other Conditions arteriosclerosis (generalized).
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. W. Michel M. D.
Address 2901 Edmondson Ave Date signed April 12 '47

G50611

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G50611

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 933 Woodyear St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ~~XXXX~~ Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 933 Woodyear
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Matilda E.Handy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Wid.

6 (b) Name of husband or wife Raymond Handy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 19, 1894

8. AGE: Years 52 | Months 5 | Days 21 | If less than one day hr. min.

9. Birthplace Md, Baltimore
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Alexender Coleman
13. Birthplace Md.

MOTHER
14. Maiden Name Mary ?
15. Birthplace Md.

16 (a) Informant Raymond Handy (Son)
(b) Address 1312 Small St.

17 (a) Burial (b) Date thereof 4/13/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Zion
Location Md.

18 (a) Funeral director Geo. W. Kelson
(b) Address 1303 Pressman St

19 APR 12 1947 Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9, 1947, at 4 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 7 1947 to Apr. 9 47 and that I last saw her alive on Apr 8 1947

Immediate cause of death: Congestive Heart Failure — Duration: 2 Week

Due to Undetermined

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George MacDonald M. D.
Address 844 N. Carey St. Date signed 4/11/47

VS 150

G50612

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30E

Registered No. G50612

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Lombard
(c) Hospital or institution: University Hospital - 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days) -?-

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1369 Gilmor St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mae Shipley

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed~~ or ~~divorced~~
M	C	M.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5, 1899

8. AGE: Years	Months	Days	If less than one day
48	-	4	hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Balto. Md
13. Birthplace Edward Shipley

MOTHER
14. Maiden Name Katherine
15. Birthplace Balto. Md

16 (a) Informant Delia Shipley
(b) Address 1153 N. Stricker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/47 (month) (day) (year)
(c) Cemetery or crematory St Peters
Location Md

18 (a) Funeral director Wes. G. Kelson
(b) Address 1303 Pressman St

19 (a) Filed by (Registrar) APR 12 1947 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/9/47 19..., at 8:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/8/ 1947 to 4/9 1947, and that I last saw h(M) alive on 4/9/47 19...

Immediate cause of death Suffocation - Impinged Aneurysm - Luetic Cardio Vascular — Duration

Due to disease — Duration

Due to ? — Duration

Other Conditions Pneumonia - Congestive Failure — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George H. Hasenberg Jr. M. D.
Address University Hosp - Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every question must be answered. Where unknown, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50613

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G50613

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2940 Wyman Pkway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2940 Wyman Parkway (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Walter E. Keene

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife ANNA SINGEWALD KEENE
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) FEB. 22 - 1881

8. AGE: Years	Months	Days	If less than one day
66	1	19	hr. min.

9. Birthplace FREDERICKSBURG VA (Town, county, and state)
10. Usual Occupation LAWYER
11. Industry or business

FATHER
12. Name SAMUEL KEENE
13. Birthplace MARYLAND

MOTHER
14. Maiden Name DEBORAH MEEKINS
15. Birthplace MARYLAND

16 (a) Informant MRS. ANNA KEENE
(b) Address 2940 WYMAN PARKWAY

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/47 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location

18 (a) Funeral director Chas J. Evans & Son Inc
(b) Address 448 N. Mt. Royal Ave

APR 12 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-11-1947, at 9:10 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D. Medical Examiner.
Date signed 4-11-47

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

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G50614

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G50614 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use typewriter if available. Do not write abbreviations. Do not write the causes of death clearly and legibly. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 31 S. Ann St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 33

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 31 S. Ann St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dante Barbini

3 (b) If veteran, name war: No.
3 (c) Social Security Account No.: None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Emilia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24 1887

8. AGE: Years 59 | Months 8 | Days 17 | If less than one day: hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Labor
11. Industry or business Balto. City

FATHER
12. Name ? Barbini
13. Birthplace Italy

MOTHER
14. Maiden Name Marion
15. Birthplace Italy

16 (a) Informant Bessie Zyski
(b) Address 31 S. Ann St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location: 4300 Belair Rd
18 (a) Funeral director: Apt. St. E. Dopalis
(b) Address 325 Conk St.

19 APR 12 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1947 at 12 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 28, 1946, to April 10 1947, and that I last saw him alive on April 9, 1947

Immediate cause of death	Duration
Coronary Occlusion	10 min.
Due to Myocardial Damage	Unknown
Emphysema	Unknown
Due to Arteriosclerosis	Unknown
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Philip Artigiani M. D.
Address 2942 E. Fayette St. Date signed 4/11/47

VS 150

G50615

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 97

Registered No. G50615

PLEASE WRITE PLAINLY, WITH UNFADING INK. Be sure to write the causes of death clearly and legibly. Be correct age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5514 Robinwood Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5514 Robinwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary C. Shipley

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Married

6 (b) Name of husband or wife Thomas F. Shipley
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 23-1860

8. AGE: Years	Months	Days	If less than one day
86	6	18	hr. 17 min.

9. Birthplace Howard Co. Maryland (Town, county, and state)
10. Usual Occupation at Home
11. Industry or business

FATHER
12. Name William Shipley
13. Birthplace Maryland

MOTHER
14. Maiden Name Ruth Musgrove
15. Birthplace Maryland

16 (a) Informant Mrs. Annie Beckes
(b) Address 5514 Robinwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 12-47 (month) (day) (year)
(c) Cemetery or crematory Mountain View
Location Howard Co. Md.

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave

19 (a) APR 12 1947 (b) [illegible]
(Date received by Local Registrar) (Signature of Local Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1947, at 4 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1944 1947 to April 10 1947, and that I last saw h alive on April 8 1947.

Immediate cause of death	Duration
Arteriosclerosis	
Gradual Debility	
Due to weak heart	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Thos. H. Shipley M. D.
Address 1939 Edmonds Ave Date signed 4-11-47

X

C50616

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Registered No. C50616

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given if possible. Underline the correct answer. Give the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Madison & Linden Ave
(c) Hospital or institution: MARYLAND GENERAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days): 7d
(e) Length of stay in Baltimore (yrs., mos., or days): 71 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State: MD. (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 1918 St. Paul St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: CHARLES HEINZ

3 (b) If veteran, name war: —

3 (c) Social Security Account No.: 213-05-3701

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 2-22-1876

8. AGE: Years: 71 | Months: 1 | Days: 19 | If less than one day: — hr. — min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: Inspector

11. Industry or business: National Casket Co.

FATHER
12. Name: Andrew Heinz
13. Birthplace: U.S.A.

MOTHER
14. Maiden Name: Carolina —
15. Birthplace: U.S.A.

16 (a) Informant: patient —
(b) Address: Hospital Records.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Apr. 12, 1947 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cem.
Location: Baltimore Md.

18 (a) Funeral director: Henry Sander & Sons Inc
(b) Address: Baltimore Md.

19 APR 12 1947 (b) Huntington Williams M.D. Registrar
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4-10 1947 at 1 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-3 1947 to 4-10 1947, and that I last saw him alive on 4-10 1947

	Duration
Immediate cause of death: Cardiac Failure	
Due to:	
Due to:	
Other Conditions: Carcinoma of head of pancreas. (Include pregnancy within 3 months of death)	

Date of operation:
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury:

23. Signature: Jesse A. Maxwell M.D.
Address: 2nd Genl Hospital Date signed 4-10-47

VS 150

X

50617

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 178a

Registered No. C50617

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3721 Hillsdale Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3721 Hillsdale Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DAISY GERTRUDE PORTS

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Walter A. Ports
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25, 1876

8. AGE: Years 70 | Months 10 | Days 15 | If less than one day hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Frank Hissey
13. Birthplace: Md.

MOTHER
14. Maiden Name: Unknown
15. Birthplace: "

16 (a) Informant: Mr. Wesley K. Ports, son
(b) Address: 3721 Hillsdale Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/47 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) APR 12 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

correct age is especially important. Physicians: please write clearly

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10, 1947 at about 3:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to illuminating gas

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-10-47 at about 3:30 P.M.
(b) Where did injury occur? 3721 Hillsdale Road
(c) Did injury occur at home, on farm, industrial place, in public place? At home While at work? No
(d) Means of injury Gas inhalation from four burners

23. Signature [signature] M.D.
Medical Examiner.
Date signed 4/[illegible]/47

VS 181

G50618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G50618

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Please see that age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd st.
(c) Hospital or institution: Union Memorial Hosp. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt.
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. ~~Ohio~~ & 39th st & Canterbury Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bertha C. Rogge.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 27, 1872

8. AGE: Years 75 | Months 0 | Days 14 | If less than one day ... hr. ... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Christian Rogge.
13. Birthplace Germany.

MOTHER 14. Maiden Name Mathilda Schromann
15. Birthplace Germany

16 (a) Informant Hosp. records.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 APR 12 1947 (Registrar's signature) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1947, at 9 25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1947, to April 11 1947, and that I last saw h.r. alive on April 11 1947.

Immediate cause of death: Cardiac Failure.
Due to: Coronary insufficiency.
Due to: Arteriosclerotic Cardiovascular disease.
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration
2 wks.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward H. Jones Jr. M. D.
Address Union Mem. Hosp. Date signed 4-11-47

VS 150

G50619

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G50619

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered; if unknown, write unknown. Do not abbreviate. Write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hosp. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. 16
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3200 Brighton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles F. Brook

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Katherine M. Brook
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26, 1882

8. AGE: Years	Months	Days	If less than one day
64	8	15	hr. min.

9. Birthplace England
(Town, county, and state)
10. Usual Occupation President
11. Industry or business Paper Box Co.

FATHER
12. Name Frederick Brook
13. Birthplace England

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Kathryn M. Brook
(b) Address 3200 Brighton St.

17 (a) Burial (b) Date thereof 4/14/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) APR 12 1947 Huntington Williams, M.D.
(Date received by registrar) (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1947, at 2.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-11 1947 to 4-11 1947 and that I last saw him alive on 4-11 1947

Immediate cause of death	Duration
Cardiac Failure	5 Min.
Due to Probable Coronary Occlusion	2 hrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William O. Gentley M.D.
Address Mercy Hosp. Date signed 4-11-47

VS 150

G50620
150392

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
1242

G50620
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ill. (b) County
(c) City or town Chicago
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5459 Cornell Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Samuel Hirsch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Helen
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) 6-9-00

8. AGE: Years	Months	Days	If less than one day
46.	8	3	..... hr. ..... min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Herman Hersch
13. Birthplace Roumania

MOTHER
14. Maiden Name Rozie Mamch
15. Birthplace Hungary

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4-12-47 (month) (day) (year)
(c) Cemetery or crematory
Location Chicago Ill

18 (a) Funeral director Jacob Lewis Inc
(b) Address 1809 E Baltimore St

APR 12 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1947, at 10.55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 15 1946 to April 12 1947 and that I last saw him alive on April 12 1947.

Immediate cause of death Uremia — Duration 3 weeks
Due to Hypertensive Cardio-Vasc. Renal disease
Due to
Other Conditions Hepatic cirrhosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Maurice B. Slaughter M. D.
Address J H H Date signed April 12 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Be sure to write the causes of death clearly and legibly. Give correct age is especially important. Physicians: please write

1310

50621

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G50621 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town [illegible] Balto
(If outside city or town limits, write RURAL and name town)
(d) Street No. 279 Herring Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harold Gorker

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frances

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1913

8. AGE: Years: 34 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia (Town, county and state)

10. Usual Occupation: Electric Welder

11. Industry or business

FATHER — 12. Name: Leon
13. Birthplace: Russia

MOTHER — 14. Maiden Name: Faga
15. Birthplace: Russia

16 (a) Informant: Frances Gorker
(b) Address: 279 Herring Court

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4-12-47 (month) (day) (year)

(c) Cemetery or crematory: Phila Pa
Location

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 1409 E. Balto St

19 (a) APR 12 1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1947, at 1:45 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Electrocution

Due to high voltage

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-11-47 at 12:50 P.M. Balto Inc.
(b) Where did injury occur? Eastern Stainless Steel Co.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial Place While at work? yes
(d) Means of injury: Came in contact with high voltage

23. Signature: Earl K. Royer M.D.
Medical Examiner.
Date signed 4-12-47

VS 151

correct age is especially important. Physicians: please write the c

the cause of death clearly and legibly.

G50622 G50622

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert and Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 HRS
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALT.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2527 E. BIDDLE ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM B. MARKLAND

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-05-3656

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 25, 1885

8. AGE: Years	Months	Days	If less than one day
62	2	17 18	hr. min.

9. Birthplace BALT., MD.
(Town, county, and state)
10. Usual Occupation JANITOR
11. Industry or business

FATHER
12. Name CHARLES MARKLAND
13. Birthplace MARYLAND.

MOTHER
14. Maiden Name ELLA BENNETT
15. Birthplace MARYLAND.

16 (a) Informant Kenneth B. Markland
(b) Address 2121 N. Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 16-47 (month) (day) (year)
(c) Cemetery or crematory Pleasant Grove
Location Balto Co.

18 (a) Funeral director J. F. Elsine & Sons
(b) Address Reisterstown Md. Huntington Williams, Md.

APR 13 1947 (Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-12 1947 at 12 20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-11 1947 to 4-12 1947 and that I last saw HER alive on 4-12 1947.

Immediate cause of death Coronary Occlusion — Duration

Due to Arteriosclerosis

Due to

Other Conditions Generalized Arteriosclerosis with Chronic Card. (Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James A. Roberts M. D.
Address Mercy Hospital Date signed 4-12-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every question must be answered. Where none, write none. Do not use ditto marks. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G50623
513814

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

52a

G50623
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford.
(c) City or town Fallston.
(If outside city or town limits, write RURAL and give town)
(d) Street No.....
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Mary Brown.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	married

6 (b) Name of husband or wife Davis Brown.
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 6-3-77.

8. AGE: Years	Months	Days	If less than one day
69	10	9	..... hr. ..... min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Hanson Cooker
13. Birthplace Md.

MOTHER
14. Maiden Name Martha Jackson
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Apr 15 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lakeside
Location Relay Md.

18 (a) Funeral director Chas. S. Sons
(b) Address Baltimore Md.

19 (a) ..... (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

APR 13 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Be sure to give correct age. Write the causes of death clearly and legibly. It is especially important. Physicians: please write the

MEDICAL CERTIFICATION

20. DATE OF DEATH April - 12 - 1947, at 6.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April - 9 1947 to April - 12 1947, and that I last saw h.. alive on April - 12 1947.

Immediate cause of death Pulmonary Embolism? — Duration .....

Due to Hypernephroma? .....

Due to ....

Other Conditions ~~Hypertension~~ ....

(Include pregnancy within 3 months of death)

Date of operation 4/12/47

Major findings of operation Kidney tumor proved by

of autopsy: Hypernephroma

PHYSICIAN
Underline the cause to which it should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury .....

23. Signature C. H. Brown M. D.

Address 4/12/47 Date signed .....

G50624

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G50624 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be answered, or the word "unknown" or the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor Ave. & Dukeland St
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2002 Eagle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs. Mary E. Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 7, 1872

8. AGE: Years 74 | Months 6 | Days 4 | If less than one day hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Calvin Etheridge
13. Birthplace Wayne County N. C.

MOTHER
14. Maiden Name Lovinia Langston
15. Birthplace Wayne County N. C.

16 (a) Informant Mrs. Annie Moore
(b) Address 2002 Eagle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Mahanta Church Cem. Location Wayne County, N. C.

18 (a) Funeral director Thomas J. Kenny, Inc.
(b) Address Hollins & Fulton Sts.

19 (a) [illegible] 19[illegible] (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11, 1947, at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 4, 1947 to Apr. 11, 1947 and that I last saw h[illegible] alive on April 11, 1947.

Immediate cause of death Cardio-respiratory failure — Duration

Due to Bronchopneumonia

Due to

Other Conditions Generalized c[illegible] cerebral arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leon Toby M.D.
Address West Balto. Gen. Hosp. Date signed 4/12/47

VS 150

G50625 BALTIMORE CITY HEALTH DEPARTMENT G50825

CERTIFICATE OF DEATH 157E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry of the causes of death clearly and legibly. Correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County Kanawha Co.
(c) City or town Rt. 1 Box 53 - Frame
(If outside city or town limits, write RURAL and give town)
(d) Street No..... (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Bonnie Jean Lowther

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: —

6 (b) Name of husband or wife: —

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 8-9-38

8. AGE: Years 8 | Months 4 | Days 24 | If less than one day ..... hr. ..... min.

9. Birthplace W. Va.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Helen Magaento
15. Birthplace ?

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof April 13/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory.....
Location Charleston, W. Va.

18 (a) Funeral director Geo. A. Mitchell & Son
(b) Address Washington Blvd. & Hillsdale, Phila. Pa.

19 (a) APR 13 1947 (b).....
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1947, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 11 1947 to Apr. 12 1947 and that I last saw her alive on April 12 1947.

Immediate cause of death Congenital Heart Disease — Duration Life

Due to.....

Due to.....

Other Conditions Tetralogy of Fallot

(Include pregnancy within 3 months of death)

Date of operation 4/12/47

Major findings of operation: Pulmonary stenosis

of autopsy: same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature Henry L. Bahnson M. D.
Address Johns Hopkins Hospital Date signed 4/12/47

G50626

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G50626 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be answered; if unknown, say so. Do not use "unknown" or "infant" unless correct age is especially important. Physicians: please write the exact cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address LakeCourt Apts - 310

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13

(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)

(d) Street No. Lindenwood Brookdale Lane
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Lena Marks Gershon (Lena Marks Gershon)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 5/1876

8. AGE: Years 70 | Months 4 | Days 7 | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

MOTHER / FATHER

12. Name Simon Marks

13. Birthplace Germany

14. Maiden Name Amelia Samuels

15. Birthplace Germany

16 (a) Informant Mrs. Cynthia Levy

(b) Address Lake Court Apts 310

17 (a) Burial (b) Date thereof Apr 14 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Westview Cemetery Atlanta Ga.

Location

18 (a) Funeral director A. Rosenstone & Sons

(b) Address 432 Eastern Ave

19 (a) (Date received by Registrar) APR 15 1947 (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/12 1947, at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1947 to 4/12 1947, and that I last saw deceased alive on 4/11 1947.

Immediate cause of death Coronary occlusion — Duration 8 hours

Due to Myocardial infarction — 2 yrs?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Frank Levman M. D.

Address 1001 Eutaw St Date signed 4/12/47

X

G50627 G50627

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 403 Cambria St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 5/12
(e) Length of stay in Baltimore (yrs., mos., or days) 9 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 403 Cambria Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Angie Webster Hancock

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-05-8984

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Winfield S.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29-1881

8. AGE: Years 65 | Months 8 | Days 14 | If less than one day hr. min.

9. Birthplace Wicomico County Md (Town, county, and state)

10. Usual Occupation Shirt Operator

11. Industry or business Bivouac Co.

FATHER 12. Name Wm H. Webster

13. Birthplace Maryland

MOTHER 14. Maiden Name Griffith Zirgle

15. Birthplace Maryland

16 (a) Informant Winfield S. Hancock

(b) Address 4 Hammond St. Salisbury Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-15-1947 (month) (day) (year)

(c) Cemetery or crematory Crisfield

Location Crisfield Md.

18 (a) Funeral director Hill-Lowe Co

(b) Address Salisbury Maryland

19 (a) 4-13-1947 (Date rec'd by registrar) (b) Clayton Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/15/1947, at 2 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to April 15 1947. and that I last saw h[illegible] alive on April 2 1947

Immediate cause of death: Carcinoma of Stomach — Duration 1 yr

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature 320 Dartmouth Ave M. D.

Address Date signed

PLEASE WRITE PLAINLY, WITH PENCIL OR PEN. Physicians: please write the causes of death clearly and legibly. Do not abbreviate. Cause antecedent to cause (b) is especially important.

VS 186

G50628 G50628

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 102

Registered No.

PLEASE WRITE PLAINLY, with pen or indelible pencil. Fill in the causes of death clearly and legibly. Give correct age in years, months, days. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkens Ave
(c) Hospital or institution: St Agnes'
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore Counties
(c) City or town ~~Baltimore~~
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1302 Poplar ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Mrs Rose Weaver~~ - Rosecarol M. WEAVER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Albert Wm.
6 (c) If alive, give age D. years

7. Birth date of deceased (mo., day, yr.) May 24-1885

8. AGE: Years	Months	Days	If less than one day
61	10	17	___ hr. ___ min.

9. Birthplace York Pa
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Thomas S Gallagher
13. Birthplace York - Pa

MOTHER
14. Maiden Name Margaret Stover
15. Birthplace York Pa.

16 (a) Informant Mrs Leroy F Charlton
(b) Address 1302 Poplar Ave Catonsville

17 (a) Burial (b) Date thereof Apr 15-'47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Patricks Cem.
Location York Pa

18 (a) Funeral director F. B. Wepfer & Son
(b) Address 1300 Eutaw Place

19 (a) Date received by registrar APR 13 1947 (b) Registrar's signature Clifton Wilson M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/10/1947, at 9 ~~P~~ AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/6/1947 to 4/10/1947, and that I last saw h alive on 4/10/1947.

Immediate cause of death	Duration
Cardiac Failure	
Due to	
Due to	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C Milton Smith Jr M D
Address St Agnes Hosp. Date signed 4/11/47

G50629

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

Registered No. G50629

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Levendale Home
(b) Street address Belvedere & Greenspring Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2838 Registerstown Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Feldman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 68 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Hyman M Smotritsky
13. Birthplace Russia

MOTHER
14. Maiden Name Bella Venze
15. Birthplace Russia

16 (a) Informant Joseph A Sohmer
(b) Address 2017 Westwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 13, 1947 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel Cem
Location German Hill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

APR 13 1947 (Date rec'd by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1947 at 4.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-24 1946 to 4-11 1947 and that I last saw h[illegible] alive on 4-11 1947.

Immediate cause of death: Carcinoma of oesophagus — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H Edmund Levin
Address Levindale Date signed 4/11/47

PLEASE WRITE PLAINLY, with unfading ink. Use write the causes of death clearly and legibly. Exact age is especially important. Physicians: please write

G50630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83B

G50630 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given as accurately as possible. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3824 Pall Mall Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3824 Pall Mall Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Blumberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late Bernard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 76 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation

11. Industry or business House Work

FATHER 12. Name Abraham Morris Yarlick
13. Birthplace Poland

MOTHER 14. Maiden Name Feronica
15. Birthplace Poland

16 (a) Informant Miss Eve Blumberg
(b) Address 3824 Pall Mall Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April,13,1947 (month) (day) (year)
(c) Cemetery or crematory Hebrew Washington Rd Cem
Location Washington Blvd

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) 1947 (Dated by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION 10.30

20. DATE OF DEATH Aptil 12 1947, at A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 19 , to 4-12 1947, and that I last saw h alive on 4/12 1947.

Immediate cause of death: Cerebral Arteriosclerosis Thrombus — Duration: 7

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Meyer Bernard

Address 7904 Reisterstown Rd Date signed 4/14/47 M.D.

VS 150

X

G50631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G50631 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be answered; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3604 Lustertown Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days): 15
(e) Length of stay in Baltimore (yrs., mos., or days) Ho yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3604 Lustertown Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna T. Hertzbach

3 (b) If veteran, name war | 3 (c) Social Security Account No.

Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) [illegible] 1897

8. AGE: Years 50 | Months | Days | If less than one day hr. min.

9. Birthplace England (town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Louis Gold

13. Birthplace Russia

MOTHER 14. Maiden Name Leta

15. Birthplace Russia

16 (a) Informant Joseph Hertzbach

(b) Address 3604 Lust Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-13-47 (month) (day) (year)

(c) Cemetery or crematory Hebrew Young Men

Location Wrightsville Rd

18 (a) Funeral director Jack Lewis Inc

(b) Address 1709 E Balto St

19 (a) Date received APR 13 1947 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-12-1947 at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1945 to April 12, 1947, and that I last saw h[illegible] alive on April 11, 1947.

Immediate cause of death: Myocardial failure — Duration about 2 yrs.

Due to: Myocarditis Fibrillation

Due to: —

Other Conditions: —

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan H. Shpritz, M. D. M. D.

Address 1810 Eutaw Pl. Date signed 4/12/47

VS 150

G50632

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1938

G50632 Registered No.

PLEASE WRITE PLAINLY, with unfading ink. Spell out full name and address or location. Do not use abbreviations. Give exact date of birth and correct age in years if possible. Be sure to fill in items 5, 6, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23. Write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Physicians: please

G50633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1218

G50633 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2119 Callow Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2119 Callow Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Sobble

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Leah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name unknown

13. Birthplace Russia

MOTHER 14. Maiden Name unknown

15. Birthplace Russia

16 (a) Informant Mrs Dorothy Cumin

(b) Address 2310 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-13-47 (month) (day) (year)

(c) Cemetery or crematory

Location Hebrew Herring Run

18 (a) Funeral director Jack Lieuty Inc

(b) Address 1439 E Baltimore St

19 (a) 4-12-1947 (b) Huntington Williams M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-12 1947, at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 21 1946, to Apr 12 1947, and that I last saw him alive on Apr 11 1947

Immediate cause of death: Pulmonary Tuberculosis — Duration: 5 mos.

Due to:

Due to:

Other Conditions: Prostatic Hypertrophy with urinary obstruction

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide:

(b) Date of occurrence: at: M

(c) Where did injury occur?: (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?: While at work?: (Specify type of place)

(e) Means of injury:

23. Signature: Louis V Blum, M.D.

Address 2310 Eutaw Place Date signed 4/13/47 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered. Be certain correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50634

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G50634 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the cause of death clearly and legibly. Certificate is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1012 S. Robinson St.
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1012 S. Robinson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Joseph Knoch

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Anna Knoch
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) 9-15-18 (1894)

8. AGE: Years	Months	Days	If less than one day
56 (47)	6	25	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Stefan Knoch
(b) Address 1015 S. Ellwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location Kenwood Hill Rd.

18 (a) Funeral director John J. Duda
(b) Address 2529 Hudson St

19 (a) (Date rec'd) (b) Washington Williams, M.D. Registrar

APR 15 1947

150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-10 1947, at 8:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 15 1946, to Apr 10 1947, and that I last saw him alive on 4-10 1947.

Immediate cause of death	Duration
Chronic Bronchial asthma	11-15-46
Lobar pneumonia	4-3-47
Due to Myocardial failure	4-10-47
Due to	
Other Conditions Nephritis	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. D.
Address 842 E. 41st Date signed 4-12-47

X

G50635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G50635 Registered No.

PLEASE WRITE PLAINLY. WITH UNFADING INK. Do not write the causes of death clearly and legibly. correct age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hosp.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6104 Old Harford Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary M. Gipe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife John H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 14 1856

8. AGE: Years 91 | Months 1 | Days 25 | If less than one day hr. min.

9. Birthplace Frederick Co Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. L. O. Harris
(b) Address 6104 Old Harford Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/16/47 (month) (day) (year)
(c) Cemetery or crematory Bals Cem
Location North Ave

18 (a) Funeral director ~~[illegible]~~ Haines & Lutz
(b) Address 1720 N. Broadway

19 (a) 1947 (b) [illegible] M. D.
(Date received by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/11/47 19 , at 3 55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/7/ 1947 to 4/11 1947 and that I last saw h alive on 4/11 1947

Immediate cause of death (a) Pneumonia, Edema

Due to (b) Coronary Failure

Due to (c) ASCVD.

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Sinai Hosp Date signed 4/11/47

X

G50636 G50636

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Light St.
(c) Hospital or institution: So Balto Gen Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18da
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1401 N. Patterson Pk. (If rural give location) W
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Matilda Salomon

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	M

6 (b) Name of husband or wife Simon Salomon 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-17-1877

8. AGE: Years	Months	Days	If less than one day: hr.	min.
69	-	27		1887

9. Birthplace Hungary (town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Isaac
13. Birthplace Hungary

MOTHER
14. Maiden Name Not Known
15. Birthplace Hungary

16 (a) Informant Husband
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-13-47 (month) (day) (year)
(c) Cemetery or crematory Levindale
Location Phila Rd & Hamilton Ave

18 (a) Funeral director Penle Levy Inc
(b) Address 1439 E Balto St

19 (a) 104 Huntington Williams, MD (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-13 1947 at 2:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-26 1947 to 4-13 1947 and that I last saw h[illegible] alive on 4-13 1947

Immediate cause of death	Duration
Hypostatic Pneumonia	
Due to Cerebral Hemorrhage	
Due to Hypertension	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Stephen H. Schwindell M. D.
Address 1211 Light St Date signed 4-13-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Be sure to write the causes of death clearly and legibly. Correct age is especially important. Physicians: please write

VS 150

1 83a

G50637

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G50637 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 3618 Hayward Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Vincent Rauzino

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Anna Rauzino
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27, 1899

8. AGE: Years	Months	Days	If less than one day
47	10	13 14	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Bricklayer
11. Industry or business General Contracting

FATHER
12. Name Jehosaphat Rauzino
13. Birthplace Italy

MOTHER
14. Maiden Name Unknown
15. Birthplace Italy

16 (a) Informant Carmen Rauzino
(b) Address 3816 Hayward Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-14-47 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location

18 (a) Funeral director C. Vernon Lemmon
(b) Address 611 Park Hgts. Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, Registrar

APR 13 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10, 1947, at 3:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 8, 1947 to April 10, 1947, and that I last saw h.. alive on April 10, 1947.

Immediate cause of death	Duration
Cardiac failure	
Due to Myocardial infarction (antemo.)	
Due to Coronary sclerosis	
Other Conditions Lobar pneumonia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sidney Green M.D.
Address Sinai Hospital Date signed 4/10/47

PLEASE WRITE CLEARLY, USING INK. Do not write the causes of death clearly and legibly. Physicians: please write correctly. Age is especially important.

V S 150

94a

G50638

BALTIMORE CITY HEALTH DEPARTMENT

MH P 76026 CERTIFICATE OF DEATH 159

G50638

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered or the word "unknown" or the correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore Genl Hosp. 20

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1626 So. Charles St.
(If rural give location)
(e) Citizen of foreign country? No! (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Carter.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/11/47

8. AGE: Years	Months	Days	If less than one day
			1 hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Edwin Charles Carter.
13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Agnetta Ida Cass
15. Birthplace Baltimore Md

16 (a) Informant Mother
(b) Address 1626 So. Charles St.

17 (a) Burial (b) Date thereof 4/14/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto

18 (a) Funeral director Wm. L. Fialkowski
(b) Address 2057 Eastern Ave, Balto, Md.

19 (a) 1947 (b) Registrar
(Date filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1947, at 11:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 11 1947 to April 11 1947 and that I last saw h[illegible] alive on 11 April 1947

Immediate cause of death
Prematurity - Respiratory failure
Due to Possible Obstruction resp. tract
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Carter
Address 1626 So. Charles St. Date signed 14 April 47
M. D.

VS 150

G50639

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G50639
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given, and every question answered. Use black ink and write the causes of death clearly and legibly. Correct age is especially important. Physicians: please write your diagnosis.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3714 Glenmore Avenue
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 17 days

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County ANN' ARUNDEL
(c) City or town ANNAPOLIS (If outside city or town limits, write RURAL and give town)
(d) Street No. 102 Gloucester ST. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) **FULL NAME** Lizzie Agnes Veazey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: FEMME | 5. Color or race: White | 6 (a) ~~Single~~ married, ~~widowed, or~~ divorced: widowed.

6 (b) Name of husband or wife: EDWARD T. Veazey

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) JAN. 17-1868

8. AGE: Years 79 | Months 2 | Days 26 | If less than one day ____ hr. ____ min.

9. Birthplace GERMANY (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business own home

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant MRS. BERTHA ULRICH
(b) Address 3714 GLENMORE AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/15/47 (month) (day) (year)
(c) Cemetery or crematory Naval Cemetery
Location Annapolis Md.

18 (a) Funeral director E. Wilbur Lamoreaux
(b) Address 1009 W. Baltimore St.

19 (a) 4-12-47 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 12 1947, at 9:12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from MAR. 28 1947, to APRIL 12 1947, and that I last saw h~~er~~ alive on APRIL 12 1947.

	Duration
Immediate cause of death: CANCER OF BREAST (LEFT) WITH PULMONARY	2 YRS +
Due to: METASTASIS	—
Due to:	
Other Conditions: SENILITY	—

(Include pregnancy within 3 months of death)

Date of operation MAY 9, 1945

Major findings of operation: CANCER OF LEFT BREAST

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Huntington Williams M.D.

Address 6631 Belair Rd. Date signed 4/12/47
Baltimore (12) Md.

G50640

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

G50640 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 days

2. USUAL RESIDENCE OF DECEASED:
(a) State N. Carolina (b) County
(c) City or town Ashboro
(If outside city or town limits, write RURAL and give town)
(d) Street No. SR 3 Worth St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Jesse Maythorne Yost

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 17, 1878

8. AGE: Years	Months	Days	If less than one day
68	6	26 25	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation School Teacher

11. Industry or business Profession

FATHER
12. Name Lewis Marshall Yost (D)
13. Birthplace Virginia

MOTHER
14. Maiden Name Letitia Chatwell
15. Birthplace Virginia

16 (a) Informant Hospital Records (UMH)
(b) Address 33rd. & Calvert Sts., Balto. 18

17 (a) Removal (b) Date thereof Apl 13-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lemon
Location Washington Co. Pa.

18 (a) Funeral director Putnam D. Lore
(b) Address 2339 N. Charles St.

19 (a) (b)
(Date received by registrar) Registrar

APR 13 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1947, at 1:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 29 19 47, to April 12 19 47, and that I last saw h.e.r. alive on April 12 19 47.

Immediate cause of death	Duration
Pulmonary Embolism	
Due to Phlebothrombosis (site undetermined)	
Due to	
Other Conditions Diabetes mellitus; Surgical resection of rectosigmoid junction for carcinoma	

(Include pregnancy within 3 months of death)

Date of operation April 2, 1947

Major findings of operation: Carcinoma of rectosigmoid junction

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. V. Kuda, M.D.
M. D.
Address Union Memorial Hospital 33rd & Calvert Sts. Date signed 4-13-47

PLEASE WRITE PLAINLY, with pen and ink. Fill all blanks. Be sure and give the causes of death clearly and legibly. Give correct age in all cases. Where the exact information is unknown, the word "unknown" should be written. Dates should be complete, as month, day, and year. The age is especially important. Physicians: please write your names plainly.

0641

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G50641 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Standard Oil Bldg. Boston & Dean Sts.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1003 S. Clinton Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Reynolds

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife [illegible] Amelia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Boiler Inspector
11. Industry or business Standard Oil

MOTHER—FATHER
12. Name Unknown
13. Birthplace "
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mary Reynolds
(b) Address 1003 S. Clinton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Herman Hill Road

18 (a) Funeral director Lilly & Zeiler
(b) Address 403 S. Wolfe St.

19 (a) 4/14/47 (Date rec'd by registrar) [illegible] M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10, 1947, at 9.50 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 26/6
(a) Date of injury 4-10-47 at about 9 a. M.
(b) Where did injury occur? Boston & Dean Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Fell to scaffold (iron)

23. Signature Earl L. Rowe M.D. Medical Examiner.
Date signed 4-10-47

correct age is especially important. Physicians: please write distinctly and legibly

VS 151

X

50612

BCH #55654

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 107

G50612
Registered No.

PLEASE WRITE PLAINLY, with ink. Use no abbreviations. Do not write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours' ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 7 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State ✓ (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2115 W. Saratoga
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas E. Broderick ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-8-46

8. AGE: Years	Months	Days	If less than one day
	7	5 6	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Marvin A. Broderick
13. Birthplace Md

MOTHER
14. Maiden Name Margaret M. Love
15. Birthplace Md

16 (a) Informant Marvin A. Broderick
(b) Address 2115 W Saratoga St

17 (a) Burial (b) Date thereof 4-15-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Baltimore

18 (a) Funeral director George A. Fahey
(b) Address Fahey Inc. 1 Fayette St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/13 1947, at 8:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5 AM 4/13 1947, to 8:15 AM 4/13 1947, and that I last saw him alive on 4/13 1947

Immediate cause of death	Duration
Respiratory failure	
Due to Anoxia	
Due to Pneumonia	weeks
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged, statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James Alex Woodson M. D.
Address Bon Secours Hospital Date signed 4/13/47

VS 150

X

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G50613

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered or the word "unknown" or the correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 34 E. Barney St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 34 E. Barney St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ellen Ella Nora Lowery

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife John E. Lowery
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 24, 1868

8. AGE: Years	Months	Days	If less than one day
79		16	hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Latcher
13. Birthplace Md.

MOTHER
14. Maiden Name Jane D. ---
15. Birthplace Md.

16 (a) Informant Family
(b) Address 34 E. Barney St.

17 (a) B (Burial, cremation, or removal) (b) Date thereof 4/14/47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Brooklyn

18 (a) Funeral director James L. McCauley
(b) Address 130 E. Fort Ave.

APR 14 1947 (Date received by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/10 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 31 1945 to 4/10 1947 and that I last saw h[illegible] alive on 4/10 1947

Immediate cause of death Carcinoma Liver. — Duration 3 mo.

Due to Carcinoma Rectum + bowel obstruction — Duration 1½ yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. J. Wheeler M. D.
Address 1279 William St. Date signed 4/13/47

X

0644 257146

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1947

Registered No. 650644

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 707 Augusta St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nathaniel Ray

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Separated

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31, 1908

8. AGE: Years 38 39 | Months 10 | Days 6 | If less than one day hr. min.

9. Birthplace Md (Town-county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER 12. Name Nathaniel Ray

13. Birthplace Md

MOTHER 14. Maiden Name ?

15. Birthplace ?

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 15, 1947 (month) (day) (year)

(c) Cemetery or crematory Mount Auburn Cemetery

Location Baltimore City

18 (a) Funeral director Mrs. Lottie Gross

(b) Address 14 N. Oakland Ave

19 APR 14 1947 (Date received by registrar) (b) Registrar Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 6 1947 at 8:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 5 1947, to Apr. 6 1947, and that I last saw him alive on Apr. 6 1947.

Immediate cause of death Heart failure — Duration 3 min

Due to Hemorrhage — 1 yr

heart disease (?) — ?

Due to Pericardial effusion (?)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. A. Hemland M. D.

Address JHH Date signed 4/11/47

X

50645 EARL Culver

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G50645

Reg# b-67498 / 108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Fountain Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2014 E. Biddle St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Earl Culver

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/10/47

8. AGE: Years	Months	Days	If less than one day
	3	1	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER: 12. Name Earl Culver
13. Birthplace Balto. Md.

MOTHER: 14. Maiden Name Anna Hilda
15. Birthplace Balto. Md.

16 (a) Informant Earl Culver
(b) Address 2014 E. Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director C. Edmund Modica
(b) Address 2661 E. Monument St

19 APR 14 1947 (Date received by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/11/47 19 , at 4:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/10 1947 to 4/11 1947, and that I last saw him alive on 4/11 1947.

Immediate cause of death	Duration
Resp. failure	
Due to Pneumonia	
Due to Pneumonia	4 days
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature August Heal, M.D.
Address Mercy Hosp Date signed 4/14/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

C50646

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered No. C50646

Please write the causes of death clearly and legibly. Physicians: please write as correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Broadway
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) 28

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Talbot -
(c) City or town Easton (If outside city or town limits write RURAL and give town)
(d) Street No. c/o Cedar Point Farms (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie Marvin (MAMIE WHEATLEY MARVIN)

3 (b) If veteran, name war: None
3 (c) Social Security Account No.:
4 Sex: Female | 5 Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorced
6 (b) Name of husband or wife: probably C. D. Marvin
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) 1-14-72
8. AGE: Years 75 | Months 2 | Days 28 | If less than one day — hr. — min.
9. Birthplace Missouri (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Hosha Trent
13. Birthplace Kentucky

MOTHER
14. Maiden Name Sarah Booth
15. Birthplace Kentucky

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial, cremation, or removal: Interment (b) Date thereof 4-14-47 (month) (day) (year)
(c) Cemetery or crematory Druid Hill Mount
Location Baltimore
18 (a) Funeral director Edward H. Mann Co.
(b) Address 1082 W. Baltimore St.
19 (c) APR 14 1947 Registrar Washington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-11-1947 at 8 M
21. I certify that death occurred on the date above stated; that I attended deceased from 3-21-47 to 4-11-1947 and that I last saw her alive on 4-11-1947

Immediate cause of death: Terminal pneumonia - Rt. lower lobe
Uremia — Duration: abt 5 days
Due to Carcinoma of Bladder — Duration: - 8 mos ?
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None (Autopsy only)
Major findings of operation:
of autopsy: as above

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature W. C. Sherman Jr. M. D.
Address Johns Hopkins Hosp. Date signed 4-11-47

VS 150

C50647

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

Registered No. C50647

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hosp. 11

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2414 Dolphin Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BEATRICE HALL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edward Hall

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 5 1914

8. AGE: Years 30 | Months 7 | Days 5 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Cook.

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name [illegible] Hall
15. Birthplace [illegible] ?

16 (a) Informant Edward Hall
(b) Address 2472

17 (a) (Burial, cremation, or removal) (b) Date thereof Apr 14 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Halstead

18 (a) Funeral director C. E. Bond
(b) Address 1900 Hill Ave

19 (c) APR 14 1947 (Date received by registrar) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10, 1947, at 11 45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet-wound of abdomen

Due to Peritonitis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4/2/47 at 4:00 A. M.
(b) Where did injury occur? 2414 Dolphin St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearms

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 4/12/47

VS 151

correct age is especially important. Physicians: please write clearly

G50618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33a

Registered No. G50618

PLEASE WRITE PLAINLY, with unfading ink. Use no abbreviations. Give the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 337- N. Biddle St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 337- N. Biddle St. (If rural give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country

3 (a) FULL NAME Lena Wilson Hughes

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race colored | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Nelson Hughes

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) June 9, 1891

8. AGE: Years 55 56 | Months 10 | Days 2 | If less than one day hr. min.

9. Birthplace Annapolis, Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name William James Polk.
13. Birthplace Prince George Co. Md.

MOTHER 14. Maiden Name Eliza Harps
15. Birthplace Maryland

16 (a) Informant Nelson Hughes
(b) Address 337 N. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/15/47 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill, Md.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) APR 14 1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11, 1947 at 1 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/10/47 to 4/11/47
and that I last saw h[illegible] 4/[illegible]/47

Immediate cause of death Bronchial Pneumonia
Grippe Type

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2 weeks

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. C. Ellis M. D.
Address 92 4 Main Date signed 4/14/47

VS 150

G50619

IL - 108767

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1928

G50619 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 45 days
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 535 Laurens St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leon Richard Gross

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Evelene
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1900

8. AGE: Years	Months	Days	If less than one day
46	4	20	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Richard
13. Birthplace Md.

MOTHER
14. Maiden Name Mary
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-15-47 (month) (day) (year)
(c) Cemetery or crematory John Wesley Cem
Location Brooklyn Howard Co. Md.

18 (a) Funeral director Mrs. Frederick B. Hemsley
(b) Address 57 E. Biddle St.

19 APR 14 1947 Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1947, at 6.20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 27 1947, to April 12 1947, and that I last saw Him alive on April 12 1947.

Immediate cause of death: Myocardial insufficiency — Duration 1 year
Due to: Mitral stenosis, rheumatic — years
Due to: Rheumatic heart disease — years
Due to: Vegetative Endocarditis — [illegible]
Due to: Cholecystitis — [illegible]
Other Conditions: Fatty degeneration of liver — [illegible]
Pulmonary infarction, [illegible]
Pulmonary artery thrombosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Laurence Lee Jr. M. D.
Address Baltimore City Hosp Date signed 4-12-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Be sure to write the causes of death clearly and legibly. Omit words not necessary to correct age is especially important. Physicians: please write

VS 150

X

G50650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G50650

PLEASE WRITE PLAINLY, with ink. Give the cause of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2400 Lestertown Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 2400 Lestertown Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Fannie Kahn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Jacob J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name Joseph Baver

13. Birthplace Russia

14. Maiden Name Freida

15. Birthplace Russia

16 (a) Informant Jacob J Kahn

(b) Address 2400 Lestertown Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-15-47 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Phila Ldr Hamilton Ave

18 (a) Funeral director Jack Lewis Inc

(b) Address 1429 E Balto St

19 (a) APR 14 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13, 1947, at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 5 1946, to April 13, 1947. and that I last saw her alive on April 13, 1947.

Immediate cause of death Carcinoma of Stomach

Due to —

Due to —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
about 2 yr.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathaniel Stupfel M.D.

Address 1810 Eutaw Place Date signed 4/15/47

VS 180

G50651

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G50651 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given and every question answered. Write the causes of death clearly and legibly. Underline the cause to which death should be charged statistically. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3551 Park Heights Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3551 Park Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lena Drapkin

3 (b) If veteran, name war	3 (c) Social Security Account No.

Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Benjamin
6 (c) If alive, give age – years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
51			hr. min.

9. Birthplace Lith (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name unknown
13. Birthplace Lith

MOTHER
14. Maiden Name Mirvan
15. Birthplace Lith

16 (a) Informant Benjamin Drapkin
(b) Address 3551 Park Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-14-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philad Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Bit
(b) Address 1409 E Balto St

19 (a) APR 14 1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-12- 1947 at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 1937 19 to Apr 12 1947 and that I last saw her alive on Apr 12 1947.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Hypertension & cardio vascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry A. Friis M. D.
Address 18 E Eutaw St Date signed 4/13/47

VS 150

50652

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G50652
Registered No.

GM, 109445

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Belto. City Hospitals 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 14 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 20 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 4
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1803 Jefferson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Speed

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-10-0980

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4-1902

8. AGE: Years 45 | Months 1 | Days 6 | If less than one day ... hr. ... min.

9. Birthplace N.C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Phillip
13. Birthplace N.C.

MOTHER
14. Maiden Name Margaret
15. Birthplace N.C.

16 (a) Informant (Records) Belto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 14-1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location A. A. Co. Md.

18 (a) Funeral director Robert E. Williams
(b) Address 1515 McElderry St

19 APR 14 1941 (Registered by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1947, at 10.40 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 26 19 47 to April 10 19 47, and that I last saw h. im alive on April 10 19 47

Immediate cause of death	Duration
Myocardial Insufficiency and failure	4 days
Due to Hypertensive Arteriosclerotic H.V.D.	10 months
Due to Pulmonary Infarction right due to Thrombosis Iliac Vein, left femoral v.	2 weeks ?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Lawrence Lee Jr. M. D.
Address Baltimore City Hosp. Date signed 4-10-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Be sure to report the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

VS 150

50653

AB-109694

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. Q50653

PLEASE WRITE PLAINLY, WITH UNFADING INK. Begin the causes of death clearly and legibly. Be correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Middle River
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rt. 14- Box 162-Baltimore 20
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Frederick Fleischmann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Anna (D)

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Sept- 26- 1868

8. AGE: Years 78 | Months 6 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Albert Fleischmann (D
13. Birthplace Germany

MOTHER
14. Maiden Name Rosa ? (D)
15. Birthplace Germany

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-15-47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Baltimore Md.

18 (a) Funeral director Leonard J. Rusk
(b) Address 5310 Harford Rd.

19 (a) APR 14 1947 (Date rec'd by registrar) (b) Registrar Hampton Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11- 1947, at 6 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-7- 1947, to 4-11 1947, and that I last saw h. alive on 4-11 1947.

Immediate cause of death	Duration
Respiratory Failure	
Due to Pulmonary Infarction	
Due to R. Phlebothrombosis	10 days
Other Conditions Arteriosclerotic C.V.D.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edmund B. Beacham M. D.
Address Baltimore City Hosp. Date signed 4-24-47

VS 150

100 B

G50654 BCH D 76433 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 159 Registered No. G50654

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Ave
(c) Hospital or institution: St. Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) New Born

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1915 E. Hoffman St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Smith.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/11/47

8. AGE: Years	Months	Days	If less than one day
			7 hr. 30 min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name ?

13. Birthplace

MOTHER 14. Maiden Name Doris

15. Birthplace ?

16 (a) Informant Hospital Records

(b) Address 1400 N. Caroline Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-14-47 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Baltimore Md

18 (a) Funeral director Leonard J. Pyrsk

(b) Address 5505 Harford Rd

19 (a) APR 14 1947 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 12 1947 at 4:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/11 1947 to 4/12 1947, and that I last saw him alive on 4-12 1947.

Immediate cause of death	Duration
Respiratory Failure	
Due to Prematurity	7hr 30 min
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation

of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James S. Shortte M. D.

Address St. Josephs Hospital Date signed 4/12/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered; if unknown, write "unknown." Use full name of person in item 3 (a); correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G50655 Blk D75310 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 159 Registered G50655

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given. Use black ink. Do not use pencil. Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Carolina Ave
(c) Hospital or institution: St Josephs Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 7

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1932 Linden Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby boy Roberson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5, 1947

8. AGE: Years	Months	Days	If less than one day
		7	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Doris I. Roberson
15. Birthplace Cumberland, Md

16 (a) Informant Hospital Records
(b) Address 1400 N. Carolina Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-14-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Leonard J. Finch
(b) Address 1345 Hanford Rd

19 (a) APR 14 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/12 1947 at 4:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/5 1947 to 4/12 1947, and that I last saw h[illegible] alive on 4/12 1947.

Immediate cause of death	Duration
Anoxia	Seconds
Due to Food Aspiration	?
Due to Prematurity	7 days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation
of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James L Shortte M.D.
Address St Josephs Hospital Date signed 4/12/47

VS 150

G50656 Cert. 109671

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V. 13 B

G50656 Registered No.

PLEASE WRITE PLAINLY with pencil or pen and ink. Physicians: please write the causes of death clearly and legibly. Give full name of deceased, whether Mr., Mrs., Miss, or Mrs. Widow. Fill in all items. Underline the cause to which death should be charged statistically. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave,
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 107 Arch St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Dorsey H Dennis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Divorced

6 (b) Name of husband or wife Sarah.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17-1894

8. AGE: Years	Months	Days	If less than one day
52	11	20	hr. min.

9. Birthplace ? Virginia (Town, county, and state)
10. Usual Occupation Laborer.
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Balto.City Hospitals .
(b) Address 4940 Eastern Ave. (Records)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 14 47. (Month) (Day) (Year)
(c) Cemetery or crematory Mt, Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director William A Jackson
(b) Address 916. Penna. Ave.

19 APR 14 1947 (Date received by Registrar) (Signature of Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7- 1947, at 2.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 5- 1947, to April 7 1947, and that I last saw h im alive on April 7 1947.

Immediate cause of death Miliary Tuberculosis — Duration ?
Due to — Duration ?
Due to — Duration ?
Other Conditions Tuberculosis Meningitis — Duration over ?
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Not obtained

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Hunt M.D.
Address Balt. City Hosp. Date signed 4-16-47

VS 150

G50657

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

Registered No. G50657

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every question must be answered, and the causes of death clearly and legibly. Use only standard abbreviations. Do not use ditto marks. If unknown, write unknown. Do not leave blanks, except when directed to do so. Be sure that the correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 906 N. Bentlou St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 906 N. Bentlou St.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore, Md. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia Marie Lauzon

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NO

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Frederick Lauzon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12, 1890

8. AGE: Years	Months	Days	If less than one day
57	0	0	hr. min.

9. Birthplace Ansonia Conn.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Joseph Cote
13. Birthplace Conn

MOTHER
14. Maiden Name Delvina Demars
15. Birthplace Canada

16 (a) Informant Florence Lacs
(b) Address 906 N. Bentlou St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/15/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Geo. W. Little
(b) Address 2700 Edmondson Ave.

APR 14 1947 (Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12th 1947, at 9:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1 1947 to Apr. 12 1947 and that I last saw her alive on Apr. 11 1947

Immediate cause of death	Duration
General visceral failure	1 month
Due to Uterine carcinoma	3 yrs.?
Due to	
Other Conditions Secondary anemia, Obesity	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lucie E Church M. D.
Address 3629 Edmondson Ave. Date signed 4/12/47

G50658 BH 015837 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 159 Registered No. G50658

PLEASE WRITE PLAINLY, with ink. Use no abbreviations. Give the causes of death clearly and legibly. correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7hrs 57min.
(e) Length of stay in Baltimore (yrs., mos., or days) same

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Worcester
(c) City or town Pocomoke City
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Townsend

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Newborn

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11, 1947

8. AGE: Years	Months	Days	If less than one day
—	—	—	7 hr. 57 min.

9. Birthplace Baltimore, Balt. Md.
(Town, county, and state)

10. Usual Occupation Newborn

11. Industry or business

FATHER
12. Name William Townsend
13. Birthplace Parksley, Va.

MOTHER
14. Maiden Name Avis Smith
15. Birthplace Pocomoke City

16 (a) Informant Mrs. Avis Smith.
(b) Address Parksley, Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/16/47. (month) (day) (year)

(c) Cemetery or crematory Pocomoke Md
Location Pocomoke City Md

18 (a) Funeral director Milton Schilling.
(b) Address 3614 Hanover St - 25 -

19 APR 14 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11, 1947, at 11:57 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 11 1947, to April 11, 1947. and that I last saw h alive on April 11 1947.

Immediate cause of death: Respiratory Failure — Duration 7hrs 57min.

Due to: Prematurity (26 Weeks Gestation) — Duration 7hrs. 57min.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. L. Ferlazzi M. D.

Address Mercy Hosp. Baltimore 2, Md. Date signed 4/11/47

VS 150

G50659 Gronemann

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G50659

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 936 N. Dunham
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 936 N. Dunham St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Hamill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary Hamill

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 17 1892

8. AGE: Years 54 | Months 4 | Days 26 | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name C. Raymond Hamill
13. Birthplace Balto

MOTHER
14. Maiden Name Ida Kron
15. Birthplace Balto

16 (a) Informant Mary Hamill
(b) Address 936 N. Dunham St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-15-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Hamilton Funeral Home
(b) Address 900 N Charles

APR 14 1947 (Date rec'd by registrar)

(b) [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-12 1947, at 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1943 to April 12 1947
and that I last saw him alive on 4/10 1947

Immediate cause of death	Duration
Coronary Thrombosis	sudden
Pulmonary Tuberculosis	15 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. Karl Gronemann M. D.
Address 212 N. Patterson Pk Ave Date signed 4/12/47

PLEASE WRITE PLAINLY with pen and ink. Be sure the causes of death clearly and legibly. correct age is especially important. Physicians: please write the

G50660

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G50660

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1004 N. Arlington Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 4 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1004 N. Arlington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Saxon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	W

6 (b) Name of husband or wife Archie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1890

8. AGE: Years	Months	Days	If less than one day
56	8		hr. min.

9. Birthplace Greenwood S. C. (Town, county, and state)

10. Usual Occupation unemployed

11. Industry or business

FATHER
12. Name Henry Mickerson
13. Birthplace S. C.

MOTHER
14. Maiden Name Eliza Matthews
15. Birthplace S. C.

16 (a) Informant Minnie Edwards
(b) Address 1004 N. Arlington Ave

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 4-15-47 (month) (day) (year)
(c) Cemetery or crematory
Location Greenwood S. C.

18 (a) Funeral director Samuel W. Culbreath Jr.
(b) Address 1947 N. Arlington Ave

19 APR 14 1947 (Date rec'd by registrar) (b) Arlington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1947, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-6 1947, to 4-12 1947, and that I last saw h[illegible] alive on 4-12 1947.

Immediate cause of death	Duration
Lenten Renal	6 Da
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. F. Fakeley
Address [illegible] Date signed 4/14/47

VS 8

A correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50661 BCH F55857 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 170c Registered No. G50661

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 761 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Shirley M. Boston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug. 12, 1942

8. AGE: Years	Months	Days	If less than one day
4	7	28	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Robert Boston
13. Birthplace Washington D.C.

MOTHER
14. Maiden Name Grace Brasel
15. Birthplace Lovell Berwick Maine

16 (a) Informant Grace E. Boston
(b) Address 761 W. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-14-47 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. Md.

18 (a) Funeral director Fred A. Dolle
(b) Address 1700 W. Lombard St.

19 APR 14 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1947, at 6:25 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE DEATH (a) Subarachnoid Hemorrhage
(b) Fracture of 6th Cervical Vertebrae
Due to
Other Conditions Fracture of left tibia & fibula, Fracture left clavicle & Shock (Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-10-47 at 6:10 P.M.
(b) Where did injury occur? Fremont Ave - 5100 Block
(c) Did injury occur at home, on farm, industrial place, in public place? public place While at work? no
(d) Means of injury Pedestrian struck by auto

23. Signature Earl L. Vogel M.D. Medical Examiner
Date signed 4-11-47

correct age is especially important. Fully describe any injury.

VS 181

G50662

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G50662

PLEASE WRITE PLAINLY with pencil or pen and write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1932 Wilkens Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1932 Wilkens Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Gertrude V. Foley

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Lawrence P. Foley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13, 1874

8. AGE: Years	Months	Days	If less than one day
73	3	27	hr. min.

9. Birthplace Washington D.C. (Town, county, and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER
12. Name William Brundridge
13. Birthplace Unknown

MOTHER
14. Maiden Name Mary E. Lockard
15. Birthplace Washington D.C.

16 (a) Informant Mrs Albert R. Barney
(b) Address 328 S. Calhoun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-14-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Fred A. Dodd
(b) Address 1200 N. Lombard St

19 APR 14 1947 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1947, at 6:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 27 1941 to Apr. 10 1947 and that I last saw her alive on Apr. 10 1947.

Immediate cause of death	Duration
Arteriosclerotic Cardio Vascular Disease	?
Due to	
Due to	
Other Conditions Hypertension	?

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —
23. Signature Carl H. Rosking M. D.
Address 1326 N. Lombard St Date signed 4/11/47

VS 150

X

G50663

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 C

Registered No. G50663

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8232 Cornwall Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert MAYGERS

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	S.

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1940

8. AGE: Years	Months	Days	If less than one day
7			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation School child
11. Industry or business

FATHER
12. Name Joseph Maygers
13. Birthplace Baltimore

MOTHER
14. Maiden Name Loretta Shriver
15. Birthplace Baltimore

16 (a) Informant Joseph Maygers
(b) Address 3232 Fait Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 15 1947 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Gorsuch Hill Rd.

18 (a) Funeral director Tilby & Zeigler Inc.
(b) Address 1603 S. W. Pk Street

19 (a) APR 14 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-11- 1947, at 9 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured skull
Intracranial hemorrhage
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4/11/47 at Balt. Co. 4 45 P. M.
(b) Where did injury occur? Sollers Pt Rd. - Dundalk
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? N.D.
(d) Means of injury struck by auto.

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 4/12/47

correct age is especially important. Any questions, please write

VS 181

G50664

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G50664

PLEASE WRITE PLAINLY with pen or pencil, and write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 635 S. Decker Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary J. Hawthorne

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Clyde

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/27/1883

8. AGE: Years 64 | Months 2 | Days 16 | If less than one day ____ hr. ____ min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Bosley
13. Birthplace Balto Co Md

MOTHER
14. Maiden Name Pauline ?
15. Birthplace Germany

16 (a) Informant Clyde Hawthorne
(b) Address 635 S. Decker Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/16/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location East End of North Ave

18 (a) Funeral director Lilly & Zeiler
(b) Address 403 S. Wolfe St.

APR 14 1947 (Date rec'd by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 APRIL 1947, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12 APRIL 1947 to 12 APRIL 1947 and that I last saw h[illegible] alive on 12 APRIL 1947

Immediate cause of death	Duration
CEREBRAL HEMORRHAGE	4 hrs.
Due to HYPERTENSIVE CARDIOVASCULAR DISEASE	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benjamin Rosenthal M. D.
Address 121 S. HIGHLAND Ave Date signed 12 APRIL 47

G50665

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G50665 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 311 S. Regester
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 311 S. Regester (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Frances Black

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Jacob

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10 86

8. AGE: Years 60 | Months - | Days 3 | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Anthony Scheppelein
13. Birthplace Balto

MOTHER
14. Maiden Name Frances ?
15. Birthplace Balto

16 (a) Informant Jacob Black
(b) Address 311 S. Regester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 16 47 (month) (day) (year)
(c) Cemetery or crematory Moreland
Location Taylor Ave

18 (a) Funeral director Selby & Zell
(b) Address 45?3 Belair Rd

19 (a) APR 14 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 April 1947, at 8:10 P.M.

21. I certify that I took charge of the remains described above, held an Inspection Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to Arteriosclerotic Hypertensive cardio-vascular disease.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer, Jr. M.D. Medical Examiner.
Date signed 13 April 47

correct age is especially important. Physicians, please write the

VS 151

X

G50666

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G50666

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1151 Carrollton Ave. (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Thomas Midgett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-12-1881

8. AGE: Years 65 | Months 5 | Days 29 | If less than one day .....hr. .....min.

9. Birthplace N. Carolina (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant Charles White
(b) Address 1202 Canal Ct. apt. A-3

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-15-47 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore County

18 (a) Funeral director William A. Jackson
(b) Address 916 Pennsylvania Ave

19 (a) APR 14 1947 (Date rec'd by registrar) Huntington Williams, M.D.

correct age is especially important. Physicians, please write

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 April 1947, at 9:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Wm. H. Kammer, Jr. M.D.
Medical Examiner
Date signed 14 April 1947

X

G50667

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered G50667

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Any information not available should be reported later. Be sure that every question is answered and that the certificate is correct and complete. Do not conceal any important fact. Do not write in spaces marked "Registrar's use only."

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1643 Ralworth Rd.
(c) Hospital or institution:

9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1643 Ralworth Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY ALICE EVANS

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Wm. H. Evans
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 18, 1867

8. AGE: Years	Months	Days	If less than one day
79	6	24	hr. min.

9. Birthplace Chase, Balto. Co., Md. (Town, county, and state)
10. Usual Occupation -
11. Industry or business

FATHER
12. Name Wm. J. League
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Rollins
15. Birthplace Md.

16 (a) Informant Mrs. George R. Kern
(b) Address 1643 Ralworth Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/15/47 (month) (day) (year)
(c) Cemetery or crematory Ebenezer Cem.
Location Chase, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

APR 14 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12, 1947, at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3- 1946, to April 12 1947, and that I last saw h alive on 19

Immediate cause of death	Duration
Carcinoma Rt Breast	3 yrs
Due to	
Due to	
Other Conditions Metastasis in Lungs (Include pregnancy within 3 months of death)	1 months

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E. North Av Date signed 4/12/47

X

50668

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered 50668

PLEASE WRITE PLAINLY, with pen and ink. Physicians: please write the causes of death clearly and legibly. Give full name of deceased, and correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1203 N. Collington Ave.
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1203 N. Collington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hannah Ritz

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife George
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 31, 1864

8. AGE: Years	Months	Days	If less than one day
82	5	10	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name William Reed
13. Birthplace Baltimore

MOTHER
14. Maiden Name not known
15. Birthplace " "

16 (a) Informant Conrad Ritz
(b) Address 1203 N. Collington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave & Rose St.

18 (a) Funeral director Clarence E. Hoffmann
(b) Address 1639 Broadway.

19 (a) APR 14 1947 (Registrar's signature) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/10 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 4, 1947 to 4/10 1947 and that I last saw h.r. alive on 4/10 1947.

Immediate cause of death	Duration
Carcinoma of Liver	6 mos
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Pakorny M. D.
Address 2200 E Madison St Date signed 4/9/47

VS 150

G50669

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G50669 Registered No.

CM.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 4'
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 43 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 662 S. Sarah Ann St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Hill

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Married

6 (b) Name of husband or wife Robert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23- 1904

8. AGE: Years	Months	Days	If less than one day
43	1	17	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Samuel Gross
13. Birthplace Md.

MOTHER 14. Maiden Name Sarah Young
15. Birthplace Md.

16 (a) Informant Records--Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof April 14 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore Md
18 (a) Funeral director Isaac L. Brown's Sons
(b) Address 1726 W. Montgomery Street
APR 14 1947 (b) Burlington Hill
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10-1947 1947, at 9.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 21 1947, to April 10 1947, and that I last saw her alive on April 10 1947.

Immediate cause of death	Duration
Respiratory Failure	
Due to Rheumatic Heart Disease	
Due to	
Other Conditions Hypertension & Nephritis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Doyle Weldon M. D.
Address B. C. H. Date signed 4-11-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Underline the causes of death clearly and legibly. Give correct age is especially important. Physicians: please write the cause to which death should be charged statistically.

VS 150

95B

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G50670 92B Register No. G50670

PLEASE WRITE PLAINLY, with ink. Use no abbreviations. Do not write the causes of death clearly and legibly. correct age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1016 N. Bentalou St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HERBERT F. WOLF
3 (b) If veteran, name war
3 (c) Social Security Account No. 214-03-3046

4. Sex	5. Color or race	6 (a) Single, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Juanita Wolf
6 (c) If alive, give age 24 years
7. Birth date of deceased (mo., day, yr.) Feb 10th 1920

8. AGE: Years	Months	Days	If less than one day
27	2	3	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Oriole Cut Rate Store

FATHER
12. Name Harold E. Wolf
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Catherine Kelley
15. Birthplace Balto. Md.

16 (a) Informant Harold E. Wolf (Father)
(b) Address 1423 Edmondson Ave
17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 4/16/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Olivet
Location Balto. Md.
18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.
19 (a) APR 14 1947 (b) (Must not be filled in by registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/13 1947 at 8 32 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/21 1947 to 4/13 1947, and that I last saw h~~im~~ alive on 4/12 1947.

Immediate cause of death Cardiac Failure — Duration
Due to Mitral stenosis
Mitral insufficiency
Due to Aortic stenosis &
Myocardial dilatation & hypertrophy
Other Conditions pertonsplasty
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stanley M. Goffe M.D.
Address Sinai Hospital Date signed 4/13

over

G50671

CWK-109834

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

G50671 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use the space for the causes of death clearly and legibly. Underline the correct age in especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 51- 3- 12-

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 114 W. Ostend Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Smith

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 1-1896

8. AGE: Years	Months	Days	If less than one day
51	3	12	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles Smith
13. Birthplace Maryland

MOTHER
14. Maiden Name Emma Barnes
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/16/47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A. A. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 307 St. Paul st

19 (a) APR 14 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1947, at 10:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 12 1947, to Apr. 13 1947, and that I last saw him alive on Apr. 13 1947.

Immediate cause of death	Duration
Aortic Stenosis	
Due to Arteriosclerotic C-V Disease.	
Due to	
Other Conditions Pulmonary Edema, Bronchopneumonia, Bilat.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: —
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert R. Faber M. D.
Address Balto City Hosp. Date signed 4-13-47

X

G50672

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Register No. G50672

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 114 W. Ostend St
(c) Hospital or institution: D.O.A. at South Balto. Gail Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 114 W. Ostend St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William F. Poyner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed, or divorced~~
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 15th 1907

8. AGE: Years	Months	Days	If less than one day
39	7	28	____ hr. ____ min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name William A. Poyner
13. Birthplace N.C.

MOTHER
14. Maiden Name Millie Smith
15. Birthplace Balto. Md.

16 (a) Informant Millie Burke (Mother)
(b) Address 114 W. Ostend St.

17 (a) Burial (b) Date thereof 4/16/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cedar Hill
Location A.A. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

19 (a) APR 14 1947 (b) Registrar
(Date rec'd by registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 April 1947 at 5:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer Jr. M.D.
Medical Examiner.
Date signed 13 April 47

correct age is especially important. Payments: please write

Huntington Williams, M.D.

G50673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1246

Registered No. G50673

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 635 E Newkirk St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto City (If outside city or town limits, write RURAL and give county)
(d) Street No. 635 E Newkirk St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harvey E. Webster

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or divorced
M	W	Widowed

6 (b) Name of ~~husband or wife~~ Annie M. Webster
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26 1876

8. AGE: Years	Months	Days	If less than one day
70	8	16	hr. min.

9. Birthplace Frederick Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Millwright

FATHER
12. Name George Webster
13. Birthplace Montgomery Co. Md.

MOTHER
14. Maiden Name Mary (Unknown)
15. Birthplace Montgomery Co. Md.

16 (a) Informant John W. Thomas
(b) Address 635 Newkirk st

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 4/15/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Oak Lawn Cem
Location [redacted] Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) APR 14 1947 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1947, at 11 50 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hepatitis, Chronic

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William E Kelbach M.D. (Medical Examiner)
Date signed April 12, 1947

correct age is especially important. Physicians: please write plainly

VS 191

G50674

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G50674

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 805 Whatcoat St
(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and name town)
(d) Street No. 805 Whatcoat St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Price

3 (b) If veteran, name war.

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 60 | Months — | Days — | If less than one day ... hr. ... min.

9. Birthplace Richmond Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Rosie Anderson
(b) Address 805 whatcoat st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/15/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. Co. Md.

18 (a) Funeral director Metropolitan Funeral Home
(b) Address 922 N. Mount St. Balto

19 APR 14 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1947, at 5-00 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Telford M.D. Medical Examiner
Date signed April 12, 1947

correct age is especially important. Physician: please write

VS 151

G50675

BALTIMORE CITY HEALTH DEPARTMENT

BC# B75658 CERTIFICATE OF DEATH 160a

Registered No. G50675

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 228 N. Myrtle Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 228 N Myrtle Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Levan Stukes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12, 1947

8. AGE: Years | Months | Days | If less than one day 3 hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Boston Stukes
13. Birthplace Lynchburg, S.C.

MOTHER
14. Maiden Name Mary Trusdale
15. Birthplace Lynchburg S.C.

16 (a) Informant Ophelia Trusdale
(b) Address 758 Waesche St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-14-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 3222 N. Johnson Ave. Huntington Station, Md.

19 (Date rec'd by registrar) APR 14 1947 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1947, at 12 03 PM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intracranial hemorrhage of new born

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

Signature Wm. J. Helfrich M.D. Medical Examiner.
Date signed April 12, 1947

correct age is especially important. Physicians, please write plainly.

VS 151

50676

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 Reg

Registered No. G50676

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Providence Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1404 W Lafayette Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry (Nabbs) Tabb

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of ~~husband~~ or wife Ella
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10, 1875

8. AGE: Years	Months	Days	If less than one day
72	1	-	hr. min.

9. Birthplace Gloucester, Va.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Peter Tabb
13. Birthplace Va

MOTHER
14. Maiden Name Martha Gant
15. Birthplace Va.

16 (a) Informant Lonia Tabb
(b) Address 1404 W. Lafayette Ave

17 (a) Burial (b) Date thereof 4 14, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 2220 N. Schroeder St

19 (a) APR 14 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/10 1947, at 11 45 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic CV disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. F. Schnabel M.D.
Medical Examiner.
Date signed 4/11/47

correct age is especially important. Physicians: please w

VS 151

X

G50677

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Register No. G50677

PLEASE WRITE PLAINLY, with ink. Use no abbreviations. Be sure to write the causes of death clearly and legibly. Be sure that the items are correct and complete. Items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23 are especially important. Physicians: please write plainly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 530 Burgundy
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 530 Burgundy
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Green.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	Widow

6 (b) Name of husband or wife Joseph Green

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) (3-1) 1877

8. AGE: Years	Months	Days	If less than one day
(70) 69	011	(10)	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joseph Commiss
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Annie Gibson
15. Birthplace Balto Md.

16 (a) Informant George Green.
(b) Address 1892 W. Lanvale St

17 (a) Burial (b) Date thereof 4-14-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 3224 N. Schroeder St.

19 (a) APR 14 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 11, 1947, at 3:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 26, 1947, to Apr 11, 1947, and that I last saw h.e alive on Apr 10, 1947.

Immediate cause of death	Duration
Uremia	3 days
Due to Nephritis	2 wks
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Donald Bando M. D.

Address 2443 W. Fall Ave Date signed 4-14-47

VS 150

Hasley X G50678

G50678

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

N 107

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 76

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town ~~Baltimore~~ Halethorpe
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1721 Selma Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** ~~Edward HASLEY~~ = EDWIN-R-HASLEY =

3 (b) If veteran, name war —

3 (c) Social Security Account No. 223-03-2415

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Gertrude L. Hasley

6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) 12-1-1886 (2-1-1887)

8. AGE: Years	Months	Days	If less than one day
59 (60)	03	11 10	hr. min.

9. Birthplace Milwaukee, Wis (Town, county, and State)

10. Usual Occupation Salesman

11. Industry or business Glass Tube Selling Co

FATHER 12. Name John Hasley

FATHER 13. Birthplace Milwaukee, Wis

MOTHER 14. Maiden Name —

MOTHER 15. Birthplace Milwaukee Wis

16 (a) Informant Mrs Gertrude L. Hasley

(b) Address 1721 Selma Ave Halethorpe

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/15/47 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director F. D. Wippert & Son

(b) Address 1300 Eutaw Place

19 (a) (Date received by registrar) (b) Huntington Williams, Registrar

APR 14 1947

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-11- 1947 at 6 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Bronchopneumonia
Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.

Date signed 4/12/47

X

Correct age is especially important. Physicians, please

G50679

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G50679 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Madison Ave
(c) Hospital or institution: Dix

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1211 Madison Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edith Allen

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Divorced

6 (b) Name of husband or wife Marion
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/19/1907

8. AGE: Years	Months	Days	If less than one day
40 11	2	23	hr. min.

9. Birthplace Va
(Town, county, and state)
10. Usual Occupation domestic
11. Industry or business

FATHER
12. Name Walter Newman
13. Birthplace Va

MOTHER
14. Maiden Name Emma Thompson
15. Birthplace Va

16 (a) Informant Fannie Graham
(b) Address 804 N. Woodyear St

17 (a) Burial (b) Date thereof 4/15/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Md

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) APR 14 1947 (b)
(Date received by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/11 1947, at 1:30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Valvular Heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Pelouze M.D.
Medical Examiner.
Date signed 4/12/47

Correct age is especially important. Physicians: please write the

G50680

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G50680

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 819 Park & 33rd & Calvert Sts
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (~~year, mos.~~, or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 819 Park Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Mrs. Mattie Naylor Malone

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband Dr. Frederick R. Malone

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb 23, 1878

8. AGE: Years 69 | Months 1 | Days 20 | If less than one day — hr. — min.

9. Birthplace Trappe, Md. (Town, county, and state)

10. Usual Occupation Housemother

11. Industry or business

FATHER 12. Name George W. Naylor

13. Birthplace Philadelphia, Pa.

MOTHER 14. Maiden Name Martha Hughlett

15. Birthplace Trappe, Maryland

16 (a) Informant Hospital record

(b) Address 33rd & Calvert Sts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 15, 1947 (month) (day) (year)

(c) Cemetery or crematory Greensboro, Md.

Location —

18 (a) Funeral director Wm. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) (Filed by registrar) (b) Registrar

14 1947

Acting for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1947, at 1:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 11 1947 to April 13 1947. and that I last saw her alive on April 13 1947.

Immediate cause of death	Duration
Generalized peritonitis	
Due to Perforation of caecum	
Due to Carcinoma of ascending colon	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation April 11, 1947

Major findings of operation: Perforation of caecum

of autopsy: perforation (caecum); carcinoma

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Henry A. Pelham M. D.

Address Union Memorial Hosp. Date signed 4-17-47

PLEASE WRITE PLAINLY. Use ink. Do not use pencil. Do not fold. Do not write above or below the lines. Be sure to write the causes of death clearly and legibly. Give correct age in especially important. Physicians: please write

G50681

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G50681 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hosp. 1615

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. xxx 923 N. Bentalou St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3.(a) FULL NAME George Washington Stallings

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 215-03-2918

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Sadie F. Stallings

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23, 1875

8. AGE: Years	Months	Days	If less than one day
71	11	19	hr. 18 min. 15

9. Birthplace Balto. Co., Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Richard E. Stallings
13. Birthplace England

MOTHER
14. Maiden Name Caroline J. Lefner
15. Birthplace Md.

16 (a) Informant Mrs. Dorothy Disney
(b) Address 923 N. Bentalou St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/15/47 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Pk.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 4-14-1947 (Date received by registrar) (b) Kenneth Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/12 1947, at 1 20 M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D.
Medical Examiner.
Date signed 4-12-47

Correct age is especially important. Physicians: please write plainly.

VS 151

G50682

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G50682

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry must be complete as to every item. Physicians: please write the cause of death clearly and legibly. Any error or omission in this certificate are is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland ✓

(b) Street address 6420 Reisterstown Road

(c) Hospital or institution: The Keton Institute

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-11-13

(e) Length of stay in Baltimore (yrs., mos., or days) 3-11-13

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Washington, D.C.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3629 Legation St., N.W.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Clara Elizabeth Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-11-1865

8. AGE: Years	Months	Days	If less than one day
82 81	11	3	hr. min.

9. Birthplace Anne Arundel County, Maryland
(Town, county, and state)

10. Usual Occupation secretary-unemployed

11. Industry or business

FATHER
12. Name Richard Brown
13. Birthplace Ellicott City, Maryland

MOTHER
14. Maiden Name Nannie Keys
15. Birthplace Maryland

16 (a) Informant The Keton Institute
(b) Address 6420 Reisterstown Rd., Balto. 15, Md.

17 (a) Burial (b) Date thereof April 16-1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Washington D.C.
Location Washington, D.C.

18 (a) Funeral director H. W. Nevinson
(b) Address 805 N. Calvert St.

19 (a) 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-14 1947, at 7:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-1 1943, to 4-14 1947, and that I last saw her alive on 4-14 1947.

Immediate cause of death	Duration
Myocardial infarct	2 weeks
Due to	
Due to	
Other Conditions psychosis with arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Romeo Pellegrino M. D.

Address 337 Windsor Ave Date signed

G50683

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G50683 Registered No.

PLEASE WRITE PLAINLY, with pen and ink. Use no abbreviations. Give the causes of death clearly and legibly. Correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 501 S. Savage St.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 501 S. Savage St.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** LOUISA KAISER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Rudolph Kaiser
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 4, 1888

8. AGE: Years	Months	Days	If less than one day
58	7	8	hr. min.

9. Birthplace Czechoslovakia
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Louis Placek
13. Birthplace Czechoslovakia

MOTHER 14. Maiden Name Barbara (unknown)
15. Birthplace Czechoslovakia

16 (a) Informant Joseph Kaiser - son
(b) Address 501 S. Savage St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/14/47 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Oak Hill
Location Horner's Lane, Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) Date received by registrar APR 14 1947 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1947, at 1 20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 8 1947, to April 12 1947, and that I last saw h[im] alive on April 11 1947.

Immediate cause of death Asthenia due to C.V. Disease
Chronic Myocarditis
Due to Congestive Failure

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: None
of autopsy: None

Duration
Jan 8/47
April 12/47

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. A. Schimunek M. D.
Address 842 S. Eutaw Date signed 4-14-47

X

G50684

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G50684

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 51
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 Hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1114 E Lexington St (If nonresidence, location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME: CHESTER Cyrus

3 (b) If veteran, name war: —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	C	

6 (b) Name of husband or wife: —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 1, 1913

8. AGE: Years	Months	Days	If less than one day
34	2	11 10	— hr. — min.

9. Birthplace South Carolina (Town, county, and state)
10. Usual Occupation Bartender
11. Industry or business

FATHER
12. Name Willie Cyrus
13. Birthplace South Carolina

MOTHER
14. Maiden Name Laura Fulton
15. Birthplace S.C.

16 (a) Informant Laura Fulton
(b) Address 1114 E. Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 15, 47 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location Baltimore Md

18 (a) Funeral director Clary O. Wilson
(b) Address 1100 Bentley Ave

19 APR 14 1947 (Date rec'd by Registrar) (b) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-11 1947, at 3:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-10 1947 to 4-11 1947 and that I last saw him alive on 4-11 1947

Immediate cause of death	Duration
Delerium Tremens	4 Days
Due to Chronic Alcoholism	10 yrs.
Due to	
Other Conditions Bronchopneumonia Endocarditis	1-2 days

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy Bronchopneumonia - Endocarditis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hayley B Heimowitz M. D.
Address 1 W Franklin St Date signed 4-12-47

777

G50685 CWK-109063

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G50688

PLEASE WRITE PLAINLY; with pen and ink. Use no abbreviations. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 22 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Turners Station (If outside city or town limits, write RURAL and give town)
(d) Street No. 107 Oak Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Celia McCacine

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Known

8. AGE: Years	Months	Days	If less than one day
22 61	?	?	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Labard Seymour
13. Birthplace Virginia

MOTHER
14. Maiden Name Maria Sprager
15. Birthplace Virginia

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 16 47 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location Brooklyn Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1010 Brantley ave

19 (a) Registrar Huntington Williams MD
APR 14 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1947, at 2:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 11 1947, to April 10 1947, and that I last saw her alive on April 10 1947.

Immediate cause of death	Duration
Respiratory Failure	1 Da
Due to Pulmonary Embolism	-
Due to Phlebothrombosis of Leg	-
Other Conditions Diabetes Mellitus Left Hemiplegia	-

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: No Post.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edmund S. Beaslian M. D.
Address Balto City Hosp. Date signed 4-22-47

VS 150

100 B

G50686

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G50686

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3310 W. Garrisone Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 36 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3310 W. Garrison Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Domenico Peri

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 213-09-9284

4. Sex: male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of wife: Pia Peri

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 21 1876

8. AGE: Years	Months	Days	If less than one day
70	5	21	hr. min.

9. Birthplace: Pitigliano Grosseto (Italy)
(Town, county, and state)

10. Usual Occupation: Presser

11. Industry or business

FATHER
12. Name: Pasquale Peri
13. Birthplace: Italy

MOTHER
14. Maiden Name: Felicissima Liberati
15. Birthplace: Italy

16 (a) Informant: Pia Peri (Wife)
(b) Address: 3310 W. Garrison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 15/47 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Rd. Baltimore Md.

18 (a) Funeral director: Frank Della Rocca
(b) Address: 52 N. Morley St.

19 (a) APR 14 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11, 1947, at 11:40 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/26/46 19__ to 4/11/47 19__ and that I last saw him alive on April 11, 1947.

Immediate cause of death: Carcinoma of the stomach — Duration: About 10 months

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Pasquale Antignani M. D.
Address 2942 E. Fayette St. Date signed 4/12/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Write correct age in all cases. Where exact age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

C50687

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47F

Registered No. C50687

PLEASE WRITE PLAINLY. Fill all blanks. Be sure to give the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Norfolk (If outside city or town limits, write RURAL and give town)
(d) Street No. 467 1st View St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Patricia Atkinsaon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-7-45

8. AGE: Years 1 | Months 5 1/2 | Days 6 | If less than one day — hr. — min.

9. Birthplace So. Carolina (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Thomas Atkinsaon
13. Birthplace Virginia

MOTHER — 14. Maiden Name Lillian Mansfield
15. Birthplace Virginia

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-14-47 (month) (day) (year)
(c) Cemetery or crematory Forest Lawn
Location Norfolk, Virginia

18 (a) Funeral director John O. Mitchell & Son
(b) Address 1864 Entow Place

19 APR 14 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-13 1947, at 7:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-11-1947, to 4-13 1947 and that I last saw her alive on 4-13-1947.

Immediate cause of death Asphyxia

Due to Mediastinal tumor

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George J. Palmer M.D.
Address Johns Hopkins Hosp. Date signed 4-15-47

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

650688 / 105 — Register 650688

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Johns Hopkins Hosp
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 125 N Washington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Eugene Hall (Eugene C. Hall)

3 (b) If veteran, name war: --

3 (c) Social Security Account No. 213-07-7487

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Rosella Hall

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 12, 1912

8. AGE: Years 34 | Months 8 | Days 29 | If less than one day hr. min.

9. Birthplace Ohio (Town, county, and state)

10. Usual Occupation Pipe Welder

11. Industry or business Beth. Steel Co. S.P.Md.

FATHER
12. Name Mace Hall
13. Birthplace Va.

MOTHER
14. Maiden Name Mamie Weitzel
15. Birthplace W.Va.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 15/47 (month) (day) (year)
(c) Cemetery or crematory Mt/Carmel Cem.
Location Balto. Md.

18 (a) Funeral director Philip Henry Gadd
(b) Address 2024 Orleans St.

19 APR 14 1947 (Date Rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1947 at 12.16 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 11, 1947 to April 11, 1947, and that I last saw h... alive on 19...

Immediate cause of death: Edema of glottis
Patient Arrived
Due to dead in accident
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: 4-12-47

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature G. G. Merrill M.D.
Address Johns Hopkins Hosp. Date signed 4/12/47

G. G. Merrill M.D. X 47

50689
513312

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓186a

Registered No. 50689

PLEASE WRITE PLAINLY, with ink. Make no erasures. Prepare the certificate before the funeral. Fill in all items. Use "None" where necessary. Be sure the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
✓ City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1226 Mr. Park St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Winfield Scott Vain.
3 (b) If veteran, name war ★
3 (c) Social Security Account No.
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 11-30-84
8. AGE: Years 62. Months 4 Days 12 If less than one day hr. min.
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Silver Smith
11. Industry or business

MOTHER / FATHER
12. Name George W.S. Vain Sr
13. Birthplace
14. Maiden Name Charlotte Hanton
15. Birthplace

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 15-47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Eastern Ave.
18 (a) Funeral director John L. Melby
(b) Address 23 & Jefferson St.
APR 14 1947 (Date received by Registrar) (By) Wm. B. Welfrich MD

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1947, at 9.10 A M
21. I certify that death occurred on the date above stated; that I attended deceased from April 10 1947, to April 12 1947, and that I last saw h[illegible] alive on April 12 1947.

Immediate cause of death: Uremia — Duration ? 1 wk
Due to: Pneumonia, R&L — ? 4 days
Due to: Arteriosclerosis general — Intertrochanteric fracture left femur — 2 wks.
Other Conditions: Shock — Paralysis Agitans
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence 4 April at 11 P M
(c) Where did injury occur? Balto., Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fall down Steps.
23. Signature [illegible] M. D.
Address Johns Hopkins Hosp. Date signed 12 April 47

VS 150

Wm. B. Welfrich MD / per G.E. Merrill MD X

G50690

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1138

G50690 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use the causes of death clearly and legibly. correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 951 N. Gay St.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME GREENER, Joseph George (brother's name Gruenmer) Wm Gruenmer or Gruenner

3 (b) If veteran, name war WWI

3 (c) Social Security Account No. 217-12-9669

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age 89 years

7. Birth date of deceased (mo., day, yr.) June 10, (1858)

8. AGE: Years	Months	Days	If less than one day
56 (88)	10	3	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Bartender

11. Industry or business

FATHER
12. Name George Gruenmer
13. Birthplace Cincinnatti, Ohio

MOTHER
14. Maiden Name Barbara ?
15. Birthplace Kentucky

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (b) Date thereof April 17-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Belair Rd.

18 (a) Funeral director John A. McIlhon
(b) Address 2334 Jefferson St.

19 (a) APR 14 1947 Huntington Williams, M.D.
(Date Registered) Address

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1947 at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 10 1947 to Apr. 13 1947 and that I last saw him alive on Apr. 13 1947

Immediate cause of death (1) Lobar pneumonia — Duration PROBABLE 5 wks.
(2) Tuberculosis, far advanced — UNKNOWN
Due to Other conditions:
Due to Cor pulmonale — UNKNOWN
Other Conditions Arteriosclerotic heart disease — UNKNOWN
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Clinical Director Date signed 4/14/47

X

G50691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G50691 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2418 E. Preston St
(c) Hospital or institution:
81
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2418 E. Preston St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter Todorow or Hodulka

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-05 8448

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ernestine Todorow

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 3, 1917

8. AGE: Years 29 | Months 7 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER: 12. Name Ompre Hodulka

13. Birthplace Russia

MOTHER: 14. Maiden Name Nellie ?

15. Birthplace Russian

16 (a) Informant Mr + Mrs Ompre Hodulka

(b) Address 2418 E. Preston St

17 (a) Burial (b) Date thereof April 15-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Family Russian
Location Stoney Run, Md

18 (a) Funeral director John A. Gretchanko

(b) Address 423 S. Eden St

19 APR 14 1947 Huntington Williams, M.D.
(Filed) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1947, at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1947 to April 10 1947; and that I last saw him alive on April 10 1947.

Immediate cause of death	Duration
Acute Cardiac Dilatation	4 hrs
Due to Pulmonary Tuberculosis	4/9/37
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas J. Reese M. D.

Address 801 N. Kenwood Ave Date signed 4/12/47

Dr Surinski 214 Medical Arts Bldg Ver 5747

Salcedo C50692

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45B

R. C50692

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2730 N. Calvert St
(c) Hospital or institution: 12

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 8 months

2. USUAL RESIDENCE OF DECEASED:
(a) ~~State~~ Cuba (b) County
(c) City or town Santiago
(If outside city or town limits, write RURAL and give town)
3
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCISCO F. FIOL (RODRIGUEZ)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Male	White	Widowed Married

6 (b) Name of ~~husband or~~ wife Maria Fiol

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 20th 1874

8. AGE: Years	Months	Days	If less than one day
72	4	23	hr. min.

9. Birthplace Palma Soriano, Cuba
(Town, county, and state)

10. Usual Occupation Retired Realtor

11. Industry or business Own Business

FATHER
12. Name Pedro Fiol
13. Birthplace Barcelona, Spain

MOTHER
14. Maiden Name Francisca Rodriguez
15. Birthplace Barcelona Spain

16 (a) Informant Rafael A. Fiol
(b) Address 2730 Calvert St. Balto. Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof April 15 1947 (month) (day) (year)

(c) Cemetery or crematory
Location Camaguey, Cuba

18 (a) Funeral director Wilkins Cook Inc
(b) Address 1307 St. Paul St.

APR 14 1947
(Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13th 1947 at 2:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 26 Nov 1946 to 13 April 1947 and that I last saw him alive on 13 April 1947

Immediate cause of death	Duration
Squamus cell Carcinoma of Tongue	12 Mos
Due to	
Due to	
Other Conditions Metastases to Liver (Include pregnancy within 3 months of death)	1 Month.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Arthur A. Surinski M. D.
Address 214 Medical Arts Bldg Date signed 14 April 47

PLEASE WRITE PLAINLY. Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

VS 150

X

G50693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G50693 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Give the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 812 N. Milton Ave.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 812 N. Milton Avenue
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK JOSEPH BOCEK

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No.:
4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Mary Klima Bocek
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 8, 1895
8. AGE: Years 52 | Months 3 | Days 4 | If less than one day hr. min.
9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business Own Electrical Business

FATHER
12. Name Joseph Bocek
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Wilhelmina Kosak
15. Birthplace Czechoslovakia

16 (a) Informant Mrs. Mary Klima Bocek
(b) Address 812 N. Milton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/15/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

APR 14 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1947 at 9 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 14 1947, to April 12 1947, and that I last saw h[illegible] alive on April 11 1947.

Immediate cause of death: Angina Pectoris — Duration: 6 yrs
Due to
Due to
Other Conditions: Diabetes Mellitus
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Vincent Kosak M.D. M. D.
Address 845 N. Patterson Pk. Date signed 4/14/47

94B

G50694

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G50694

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 535 Bloom St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 536 Bloom St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter Bell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Mary Ella

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17 1860

8. AGE: Years 87 | Months 4 | Days 24 | If less than one day: hr. min.

9. Birthplace Prince George Co. Md
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name — ? Bell
13. Birthplace Prince George Co. Md

MOTHER
14. Maiden Name Sophia — ?
15. Birthplace Prince George Co. Md.

16 (a) Informant Mrs. Rita West
(b) Address 536 Bloom St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-16-1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. George F. Holland
(b) Address 1631 Druid Hill Ave.

19 (Signature of registrar) APR 15 1947 Washington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/14/47, at 7:54 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/28/47 to 4/14/47 and that I last saw him alive on 4/14/47.

Immediate cause of death: Cerebral Hemorrhage
Due to: Paralysis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Chetta, M.D.
Address 536 Bloom St Date signed 4/15/47

VS 190

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G50695

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 46E

Registered No. G50695

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edmond & Greene
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days) "

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town New Windsor
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? .....(Yes or No)
If yes, name country .....

3 (a) FULL NAME Daniel Bohn

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 213-16-1577

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife: Lillie Bohn
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 2 - 1897

8. AGE: Years 50 | Months 1 | Days 13 | If less than one day ..... hr. ..... min.

9. Birthplace Frederick County, Md
(Town, county and state)

10. Usual Occupation Truck Driver

11. Industry or business

FATHER
12. Name George Bohn
13. Birthplace Maryland

MOTHER
14. Maiden Name Hettie Fogle
15. Birthplace Maryland

16 (a) Informant Wife
(b) Address Above

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/17/47 (month) (day) (year)
(c) Cemetery or crematory Beaver Dam Cem
Location Frederick County, Md

18 (a) Funeral director Hill, Hartley & Stone
(b) Address Thomas Bridge & New Windsor Md

19 (a) Apr 15 1947 Registrar by Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-15 1947, at 1 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-24 1947 to 4-15 1947, and that I last saw him alive on 4-15 1947.

Immediate cause of death: Cardiac-Resp Failure — Duration .....
Due to Carcinoma Sigmoid — .....
Due to ..... — .....
Other Conditions Diabetes Mellitus — .....
(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: Carcinoma of Sigmoid
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature [illegible] M. D.
Address [illegible] Date signed 4-15-47

VS 150

G50696

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. G50696

PLEASE WRITE PLAINLY, with ink. Fill in all blanks. Be sure to state the causes of death clearly and legibly. Give the correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 450 E. 28th Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 450 East 28th Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Sue Carney

3 (b) If veteran, name war W
3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 7, 1876

8. AGE: Years	Months	Days	If less than one day
71	3	7	hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Pasquith
13. Birthplace Virginia

MOTHER
14. Maiden Name Lucy Chitwood
15. Birthplace Virginia

16 (a) Informant Mrs. Reuben Moxley
(b) Address 450 East 28th Street

17 (a) Burial (b) Date thereof 4/16/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 APR 15 1947 (b)
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14, 1947 at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 15 1947 to Apr 14 1947 and that I last saw her alive on March 1947.

Immediate cause of death	Duration
Coronary Thrombosis	Immediate
Due to Coronary Sclerosis	Indefinite
Due to Chronic Myocarditis	Indefinite
Other Conditions Generalized Arteriosclerosis Small Thrombosis 2 Mos ago	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nathaniel W. Beck M. D.
Address 1005 E. 33rd St Date signed Apr 18-47

VS 150

C50697

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

Registered C50697

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Give correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2403 Calvert Nghts
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2403 Calvert Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida May Shipley

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Charles A Shipley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21, 1864

8. AGE: Years	Months	Days	If less than one day
80	8	20	21 hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

MOTHER FATHER 12. Name	Joseph A Crouse
13. Birthplace	Maryland
14. Maiden Name	Cassandra M Roberts
15. Birthplace	Tennessee

16 (a) Informant John A Shipley
(b) Address 2403 Calvert Heights Ave

17 (a) Burial (b) Date thereof 4/16/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md
18 (a) Funeral director Wilson & Son Inc
(b) Address 1217 Park Ave
19 (a) APR 15 1947 (b) Huntington Williamson, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1947, at 10 55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1946 to April 1947 and that I last saw her alive on Dec 12 1946

Immediate cause of death Cerebral hemorrhage — Duration
Due to Hypertension
Due to Arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J Holmick M.D.
Address 1710 Liberty Hts Date signed 4/14/47

X

G50698 BALTIMORE CITY HEALTH DEPARTMENT G50698

CERTIFICATE OF DEATH X 93c

Registered No.

PLEASE WRITE PLAINLY. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3602 Chesterfield Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Tad
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rural
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes Hopkins

3 (b) If veteran, name war: ~~X~~

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Female	White	Married

6 (b) Name of husband ~~or wife~~: Edward Benj. Hopkins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 8th 1893

8. AGE: Years	Months	Days	If less than one day
54	2	6	hr. min.

9. Birthplace Scotland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name James Henderson
13. Birthplace Scotland

MOTHER
14. Maiden Name Elizabeth Buckhannon
15. Birthplace Scotland

16 (a) Informant Mrs Mildred Tunnicliff Daughter
(b) Address 3602 Chesterfield Ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4/15/47 (month) (day) (year)

(c) Cemetery or crematory Cline's
Location Kanawha Co. W. Va.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st.

19 (a) APR 15 1947 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14th 1947, at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/5 1947 to 4/14 1947 and that I last saw h alive on 4/14 1947

Immediate cause of death: Coronary Thrombosis

	Duration
Due to	
Due to	
Other Conditions Cardio-Vascular Disease Probable Rheumatic Basis (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. B. Stevens M. D.
Address 340 Tuckahoe Ave Date signed 4/14/47

VS 150

X

G50699

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓107

Registered No. G50699

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be made in this form. Do not write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4415 Forest View Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4415 Forest View Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME ROSA A. FRANK

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	Widowed

6 (b) Name of husband or wife Ernest Frank
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 11, 1872

8. AGE: Years	Months	Days	If less than one day
75	2	1	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Matthias Woessner
13. Birthplace Germany

MOTHER
14. Maiden Name Maria Dreschler
15. Birthplace Germany

16 (a) Informant Mr. John A. Woessner
(b) Address 4414 Forest View Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Apr. 15, 1947 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Balto., Md.

18 (a) Funeral director Lyndon Funeral Home
(b) Address 7401 Belair Road

19 APR 15 1947 (Date received by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12th, 19 47 at 6:05AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/7/ 1947 to 4/12 1947, and that I last saw h[illegible] alive on 4/11/ 1947

Immediate cause of death Bronchopneumonia — Duration 5 days

Due to

Due to

Other Conditions Chr. Hypertrophic arthritis + arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D. T. Bratton M. D.
Address 5829 Belair Rd Date signed 4/14/47

X

50700

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 94a

Registered No. C50700

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hr.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Denton
(If outside city or town limits, write RURAL and give town)
(d) Street No.....
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME. James Neighbors

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Nurse Debrela Neighbors

6 (b) Name of husband or wife

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Nov. 5th 1890

8. AGE: Years	Months	Days	If less than one day
56	6 5	8 5	....hr. ....min.

9. Birthplace Near Denton Md
(Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name George Neighbors
13. Birthplace Maryland

MOTHER
14. Maiden Name Jennie Bish
15. Birthplace Maryland

16 (a) Informant Lewis Butler
(b) Address Denton Md

17 (a) Buried (b) Date thereof 4-13-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Denton Cemetery
Location Denton Md

18 (a) Funeral director Virgil Meredith Long
(b) Address Huntington Methodist, Md

19 APR 15 1947 (b).....
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1947, at 9:5 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature Earl L Ryan M.D.
Medical Examiner.
Date signed 4-16-47

correct age is especially important. Physicians: please write

VS 181

X

50701

Bk # B-74568

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √159

G50701
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Be sure that the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 2 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1623 Division St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby of Francis Frazier

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-15-47

8. AGE: Years | Months | Days | If less than one day: 2 hr. 5 min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name David Llewellyn Frazier

13. Birthplace Towson Md

MOTHER — 14. Maiden Name Frances Butler

15. Birthplace Balto. Md

16 (a) Informant Frances Frazier

(b) Address 1623 Division St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School APR 10 1947

18 (a) Funeral director Commissioner of Health

(b) Address

APR 15 1947 Huntington Williams M.D.
(Local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-16 1947, at 12 50 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-15- 1947, to 3-16- 1947, and that I last saw him alive on 3-16- 1947.

Immediate cause of death	Duration
Due to Premature	28 wks.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis Tenney M.D.

Address 1102 Druid Hill Ave Date signed 4/9/47

VS 150

X

50702

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G50702
Registered No.

BC# B-14570 161a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: President Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4½ hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 4½ hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1623 Lemmon Court Glenn Haven
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby of Veronica White
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	negro	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 24, 1947

8. AGE: Years	Months	Days	If less than one day
			4½ hrs. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Silas Nathaniel White
13. Birthplace White Stone Va.

MOTHER
14. Maiden Name Veronica Damas
15. Birthplace Pensacola Fla.

16 (a) Informant Veronica White
(b) Address 1623 Lemmon Court

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School APR 10 1947
18 (a) Funeral director Commissioner of Health
(b) Address
APR 15 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-24-1947, at 11 25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1 25 3-24-1947, to 11 25 3-24-1947, and that I last saw h.i.m. alive on 3-24-1947.

Immediate cause of death	Duration
Due to stelectasis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature N. Louis Young M. D.
Address 1100 Druid Park Dr. Date signed 4/8/47

VS 150

G50703

Dr. M. Wyman Birth Certificate G-15845

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G50703
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be made in permanent black ink or typewritten. Do not abbreviate. Write the causes of death clearly and legibly. Give full name of deceased. If not in hospital or institution, give residence instead of hospital or institution. If residence is outside city limits, so state. If death occurred in hospital or institution, the physician must forward certificate within 24 hours after death occurs. If dead body is found, the physician must forward certificate within 24 hours after being notified. Before burial, removal, or cremation, the undertaker must obtain permit from the Registrar of Vital Statistics. Give correct age in years, months, days, hours, or minutes. Physicians: please write the causes of death clearly and legibly. Physicians are especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 13 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1639 E. Monument St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby of Beulah Howard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-14-47

8. AGE: Years	Months	Days	If less than one day
			13 hrs. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Leroy Howard
13. Birthplace Gayden N. C.

MOTHER
14. Maiden Name Beulah Griffin
15. Birthplace Balto. Md

16 (a) Informant Beulah Howard
(b) Address 1539 E. Monument St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School APR 10 1947

18 (a) Funeral director (Commissioner of Health)

(b) Address

19 APR 15 1947 (Date rec'd by registrar) Hardy & Williams MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-14- 19 47 at 11 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11 am 3-14-47 19 to 11 45 Pm 3-14-1947 and that I last saw him alive on 3-14- 19 47

Immediate cause of death	Duration
Atelectasis	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mabel Odom MD

Address 238 N Carey St Date signed 3-17-47

X

50704

BALTIMORE CITY HEALTH DEPARTMENT

G50704 Registered No.

BC# D80676 CERTIFICATE OF DEATH V161a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Providence Hospital 19

(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 517 N. Parkside St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rae Scott

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/3/47

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

MOTHER | FATHER
12. Name
13. Birthplace
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School APR 10 1947 Commissioner of Health

18 (a) Funeral director
(b) Address

19 APR 15 1947 (Date rec'd by registrar) Registrar

correct age is especially important. Physicians: please write plainly.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/6/47 19 , 20 hrs M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Atelectasis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature D. P. Faulconer M.D.
Medical Examiner.
Date signed 4/6/47

0705

Bk # 974032

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161a

G50705

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1217 Pennsylvania Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1212 Pennsylvania Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Emanuel Briscoe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/23/47

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name
13. Birthplace
MOTHER 14. Maiden Name
15. Birthplace
16 (a) Informant
(b) Address
17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School APR 10 1947
18 (a) Funeral director Commissioner of Health
(b) Address
19 APR 15 1947 (Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1947, at 7:00 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Atelectasis, Neonatorum

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William F. Helfrich M.D.
Medical Examiner.
Date signed March 26, 1947

correct age is especially important. Physicians, please write plainly.

VS 151

0706 G50706

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: 4
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 415 E. Baltimore St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Nicholas Franke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years	Months	Days	If less than one day
45			.....hr. .....min.

9. Birthplace.....
(Town, county, and state)

10. Usual Occupation.....
11. Industry or business

FATHER
12. Name.....
13. Birthplace

MOTHER
14. Maiden Name.....
15. Birthplace

16 (a) Informant.....
(b) Address

17 (a).....(b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory.....
Location.....

University Medical School APR 10 1947
Commissioner of Health

18 (a) Funeral director.....
(b) Address.....

19 APR 15 1947
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1947, at 3 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Subarachnoid Hemorrhage (Spontaneous)

Due to Hypertension C.V. Disease

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature.....M.D.
Medical Examiner.
Date signed.....

correct age is especially important. Physicians, please write plainly.

VS 181

50707

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G50707
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dom
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 113 N. Paca St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William J. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 55 | Months | Days | If less than one day ....hr. ....min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

University Medical School APR 10 1947
Commissioner of Health

18 (a) Funeral director

(b) Address

19 APR 15 1947
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1947, at 10:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L. Reyer M.D.
Medical Examiner.
Date signed 3-31-47

correct age is especially important. Physicians: please write

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50708

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G50708 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 753 W. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JACOB UZELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 77 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School APR 10 1947

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) APR 15 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 191

correct age is especially important for veterans. Please check.

MEDICAL CERTIFICATION 55

20. DATE OF DEATH April 1, 1947, at 11 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic heart disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 4/1/47

X

G50709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G50709

PLEASE WRITE PLAINLY, with unfading ink. Do not use pencil. Do not write the causes of death clearly and legibly. correct age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 130 S. Patterson Pk Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 130 S. Patterson Pk Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Helen Zukowski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 16 '47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Ozarowski
(b) Address 1936 Eastern Ave

19 (a) APR 15 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1947, at 1 A. M

21. I certify that death occurred on the date above stated, that I attended deceased from 10/5 1946 to April 14 1947, and that I last saw h[illegible] alive on April 14 1947

Immediate cause of death PULMONARY EDEMA — Duration 4/14/47

Due to HYPERTENSIVE CARDIO-VASCULAR DISEASE — 10/5/46

Due to

Other Conditions CHRONIC ARTHRITIS — 22

(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph F. Hyerza, M.D.
Address 20[illegible] Porter St. Date signed 4/16/47

VS 150

G50710

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered No. G50710

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2512 Halcyon Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2512 Halcyon Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie E. Dankert

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Paul R. Dankert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 27, 1888

8. AGE: Years	Months	Days	If less than one day
58	3	15	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Martin Lang
13. Birthplace Germany

MOTHER
14. Maiden Name Hanna Retiger
15. Birthplace Balto. Md.

16 (a) Informant Mr. Paul R. Dankert
(b) Address 2512 Halcyon Ave.

17 (a) Burial (b) Date thereof Apr. 15/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto. Md.

18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Orleans St.

19 APR 15 1947 (b) Washington Millinery
(Local registrar)

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MEDICAL CERTIFICATION

20. DATE OF DEATH April 11/47 19 , at 11.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1947, to April 11 1947, and that I last saw h[illegible] alive on April 11 1947.

Immediate cause of death	Duration
Coronary Thrombosis	1 Day
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 2878 Harford Rd Date signed 4-15-47

PLEASE WRITE PLAINLY, with ink or indelible pencil. Fill in all items. Be sure to write the causes of death clearly and legibly. Be sure that the information given is correct as it is especially important. Physicians: please write the cause of death clearly and legibly.

50711

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G50711

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2427 Gutaw Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ida Rosenbloom - (Ida Rosenbloom)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Jacob

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 69 | Months | Days | If less than one day hr. min.

9. Birthplace Lith (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name unknown

13. Birthplace Lith

MOTHER 14. Maiden Name unknown

15. Birthplace Lithuania

16 (a) Informant Julius Offit

(b) Address 3300 Fairview Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-15-47 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc

(b) Address 1639 E Baltimore St

19 (a) (Signature) (b) Huntington Williams, M.D. Registrar

APR 15 1947

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-14 1947 at 8:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-11 1947, to 4-14 1947, and that I last saw her alive on 4-14 1947.

Immediate cause of death	Duration
Coronary Occlusion	
Due to Arteriosclerotic Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan B. Herman M. D.

Address Sinai Hospital Date signed 4-14-47

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G50712

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G50712

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be made on this certificate before any copies are made. Please write the causes of death clearly and legibly. Use only standard abbreviations. Do not use ditto marks. Be sure that the entry in each item is complete. Do not leave any blanks. If unknown, write "unknown." If there is no entry for any item, write "none." Please answer all questions. Be sure that the date of death is complete and correct. Be sure that the cause of death is correct and complete. Be sure that the age is correct. Physicians: please write the cause of death clearly and legibly. Be sure that the age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1311 McElderry St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 11
(e) Length of stay in Baltimore (yrs., mos., or days) 33 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1311 McElderry St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Barnes
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male
5. Color or race Col.
6 (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7 1897
8. AGE: Years 49 Months 11 Days If less than one day hr. min.
9. Birthplace Fayetteville N.C. (town, county, and state)
10. Usual Occupation Share Keeper
11. Industry or business

FATHER
12. Name Granville Barnes
13. Birthplace Fayetteville NC

MOTHER
14. Maiden Name Martha King
15. Birthplace Fayetteville NC

16 (a) Informant Georgia Currie
(b) Address 15 27 Jefferson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Willis Creek Cemetery
Location Fayetteville N.C.

18 (a) Funeral director Robert W. Williams
(b) Address 1515 McElderry St

19 (a) (Date received by local registrar) APR 15 1947 Registrar Washington, D.C.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1947, at 12:29 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-1 1947 to 4-13 1947 and that I last saw him alive on 4-13 1947.

Immediate cause of death
Uremia - Renal
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature D. J. Hatcher M.D.
Address 1515 Park Ave Date signed 4/15/47

VS 150

50713

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 50713

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1025 Jenkins St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1023 Jenkins St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Mason

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife former
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-6-1878

8. AGE: Years	Months	Days	If less than one day
69	2	9	hr. min.

9. Birthplace Eastern Shore Md. (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Md.

16 (a) Informant William A. Gibson
(b) Address 1025 Jenkins St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-18-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location Cedar Hill Md.

18 (a) Funeral director Adolphus Halstead
(b) Address 2417 Druid Hill Ave.

19 APR 15 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-13 1947, at 1:A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-8 1946 to 4-15 1947 and that I last saw her alive on 4-12 1947.

Immediate cause of death	Duration
Hypertension	
Hydrovarcele, Disease	2 yr.
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Atwell Jones M. D.
Address 534 Dolphin St. Date signed 4-15-47

VS 150

Please write the cause of death clearly and legibly. Physicians: please write correct age is especially important.

G50714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G50714

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1827 N. Chapel St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1827 N. Chapel St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Colinton

3 (b) If veteran, name war: Yes. World I
3 (c) Social Security Account No. 215-10-3040

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Ruth Smith Colinton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4, 1895

8. AGE: Years	Months	Days	If less than one day
52	3	14	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Chauffeur and Janitor
11. Industry or business Hutt Dept. Store

FATHER
12. Name Patrick Colinton
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Elizabeth Wallace
15. Birthplace Ireland

16 (a) Informant Mrs. Ruth Colinton
(b) Address 1827 Chapel St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 17 1947 (month) (day) (year)
(c) Cemetery or crematory Baltimore National Cem.
Location 5501 Frederick Rd.

18 (a) Funeral director Edgar W. Conklin & Son
(b) Address 224 E. Eager St.

APR 15 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13, 1947, at 3P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/2 1947, to 4/11 1947 and that I last saw h.im alive on 4/11 1947

Immediate cause of death: Acute coronary infarction — Duration

Due to: Chronic Coronary Sclerosis

Due to: Coronary insufficiency

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. L. Hornstein M. D.
Address 733 Argyle St. Date signed 4/14/47

X

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G50715

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G50715 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1731 Darley Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1731 Darley Ave (If rural give location)
(e) Citizen of foreign country? / (Yes or No)
If yes, name country

3 (a) FULL NAME Kate Hoerdt

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: no

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22, 1864

8. AGE: Years 82 | Months 11 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Home work
11. Industry or business at Home

FATHER
12. Name Henry Hoerdt
13. Birthplace Germany

MOTHER
14. Maiden Name Sarah Kinburn
15. Birthplace "

16 (a) Informant Mr. John P. Hoerdt
(b) Address 1731 Darley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/18/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location 4430 Belair Rd

18 (a) Funeral director Clarence W. Capkline & Son
(b) Address 2216 E. Eager St

19 (a) APR 15 1947 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14, 1947, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 Jan 1947, to 14 Jan 1947, and that I last saw her alive on 13 Jan 1947.

Immediate cause of death (a) Uremia ? Acute, (b) Pulmonary Insufficiency, (c) , (d) , Duration (a) 4 days (b) 3 hrs (c) 20 yrs (d) 20 yrs (e) 2 mos

Due to (a) Arteriosclerotic cardio-vascular Renal Disease

Due to (b)

Other Conditions Generalized Hypertrophic arthritis, Decubitus Ulcer, Pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: none

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward L. J. Mark M. D.
Address 7329 Harford Rd Date signed 14 April 47

X

Correct age is especially important. Physicians: please write plainly.

Rose V.

G50716

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered G50716

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton and Wilkens Ave.
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1124 Barclay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose V. Madden

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife Thomas J. Madden | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6, 1876

8. AGE: Years	Months	Days	If less than one day
70	10	7	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation House work
11. Industry or business at Home

FATHER: 12. Name Michael McKenna
13. Birthplace Ireland
MOTHER: 14. Maiden Name Catherine Walsh
15. Birthplace Maryland

16 (a) Informant Mrs. Christopher Dillon
(b) Address 2917 Catalpha Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 17th (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cemetery
Location 4300 Old Frederick Rd.

18 (a) Funeral director Edward W. Coughlin
(b) Address 92 E. Eager St.

19 (d) APR 15 1947 (Date rec'd by registrar) (b) Washington, D.C.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/13 19 47 at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/26 19 47 to 4/13 19 47 and that I last saw h.e. alive on 4/13 19 47.

Immediate cause of death: Cardiac failure
ACUTE Cholecystitis
+ Myocardial infarct

Duration

Due to Pneumonia

Due to

Other Conditions Generalized arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address Eagle St. Date signed 4/15/47 (M. D.)

G50717 B74880 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 159 G50717

PLEASE WRITE PLAINLY, with pen and ink. Use no abbreviations. Write the causes of death clearly and legibly. Give the correct age in every case where it is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 876 Washington Blvd.
(c) Hospital or institution: Doctors Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2212 Riggs Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby boy Fletcher (A)

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/6/47

8. AGE: Years	Months	Days	If less than one day
			hr. 5 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Harry V. Fletcher
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Kemp, Margaret Louise
15. Birthplace Ridgely, Maryland

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School APR 8 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 APR 15 1947 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-6-47 19 , at 1:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-6- 1947, to 4-6- 1947, and that I last saw h im alive on 4-6- 1947.

Immediate cause of death

	Duration
Prematurity-30 weeks.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 733 Gentry Rd Date signed

X

G50718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G50718

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Westminster (If outside city or town limits, write RURAL and give town)
(d) Street No. 169 W. Main St (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) **FULL NAME** Baby Girl Petry

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-25-47

8. AGE: Years | Months | Days: 7 | If less than one day .....hr. .....min.

9. Birthplace Westminster, Maryland (Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER 12. Name Chas. Conaway
13. Birthplace Md

MOTHER 14. Maiden Name Alva (Elva Petry)
15. Birthplace Md.

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a)..... (b) Date thereof..... (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory.....
Location Johns Hopkins Medical School APR 7 1947

18 (a) Funeral director Commissioner of Health
(b) Address.....

19 APR 15 1947 (Date rec'd by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1947, at 7 05 M

21. I certify that death occurred on the date above stated, that I attended deceased from 3-26 1947 to April 1 1947 and that I last saw h. alive on..... 19.....

Immediate cause of death	Duration
Respiratory failure	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature Richard E. Dorman M. D.
Address Johns Hopkins Hosp. Date signed 4/2/47

PLEASE WRITE PLAINLY with pen and ink. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G50719 **HEALTH DEPARTMENT—CITY OF BALTIMORE** G50719

BC# D 75021

CERTIFICATE OF DEATH

84a

Wd. of Amer. Hosp.

1. PLACE OF DEATH — Registered No.

CITY OF BALTIMORE: (No. 418 W. Lexington St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ da. How long in U. S. If of foreign birth? ___ yrs. ___ mos. ___ da.

2. FULL NAME Joyce Ann Langston wD — If U. S. Veteran specify WAR ___

(a) Residence: No. 1265 Calverton Road St., ___ Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	W	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) March 24, 1947

7. AGE Years	Months	Days	If LESS than 1 day ___ hrs. or ___ min.
		17	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Beels Md

FATHER

13. NAME Carl J. Langston

14. BIRTHPLACE (city or town) (State or country) Goldsboro N.C.

MOTHER

15. MAIDEN NAME Maxine Gale

16. BIRTHPLACE (city or town) (State or country) Lynchburg, Va.

17. INFORMANT Maxine Langston
(Address) 1265 Calverton Rd.

18. BURIAL, CREMATION, OR REMOVAL
Place Johns Hopkins Medical School APR 11 1947

19. UNDERTAKER Commissioner of Health
(Address)

20. APR 15 1947 [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) April 10, 1947

22. I HEREBY CERTIFY, That I attended deceased from March 24, 1947 to April 10, 1947

I last saw her alive on April 10, 1947 Death is said to have occurred on the date stated above, at 5:30 p.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
(1) Mongolian Idiot & deformities of all extremities	at birth
(2) Respiratory failure	Apr. 7th
Other contributory causes of importance:	

Was an operation performed? ___ Date of ___

For what disease or injury? ___

Name of operation ___

What test confirmed diagnosis? ___ Was there an autopsy? ___

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? ___ Date of injury ___, 19___

Where did injury occur? ___
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ___

Manner of injury ___

Nature of injury ___

24. Was disease or injury in any way related to occupation of deceased?
If so, specify ___

(Signed) Leonard Yaffe M. D.
(Address) Valentine & Spike

State CAUSE OF DEATH, OCCUPATION in very important. See instructions on back of certificate.

50720 B-74881

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

✓ G50720 Registered No.

PLEASE WRITE PLAINLY, with pen or pencil. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 876 Washington Blvd.
(c) Hospital or institution: Doctors Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2212 Riggs Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby boy Fletcher (B)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/6/47

8. AGE: Years	Months	Days	If less than one day
			hr. 5 min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Harry E. Fletcher
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Kemp, Margaret Louise
15. Birthplace Ridgely, Maryland

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School APR 8 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 APR 15 1947 (Date rec'd by registrar) Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-6-47 19 at 1:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-6 1947 to 4-6 1947.
and that I last saw [illegible] alive on 4-6 1947

Immediate cause of death Prematurity 3 hours

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide at M
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address 333 Eutaw Pl. Date signed

0721

AB-98503

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

G50721 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26-
(d) Length of stay in hospital or inst. (yrs., mos., or days) lyr-2mos-16days
(e) Length of stay in Baltimore (yrs., mos., or days) 31yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. No Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Karagonis-or-John Karagunis-or- John Karazgonis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2- 1870

8. AGE: Years 76 | Months 10 | Days 26 | If less than one day hr. min.

9. Birthplace Greece (Town, county, and state)

10. Usual Occupation Dishwasher

11. Industry or business

FATHER
12. Name Ollie Karagonis-or Ernest Karagunis-or John Karzgonis
13. Birthplace Greece

MOTHER
14. Maiden Name Kaliopi-or-Caliope-or-Mary
15. Birthplace Greece

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Location [illegible] APR 8 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 APR 15 1947 [signature] M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28-19 1947, at 6 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-12 19 46 to 3-28 19 47 and that I last saw h. in alive on 3-28- 19 47.

Immediate cause of death	Duration
Cardiac Insufficiency	?
Due to Arterio sclerotic heart disease	10 yrs
Due to Laennec's Cirrhosis	5 yrs
Due to Alcoholism, chronic	30 yrs.
Other Conditions Pulmonary Emphysema, Hernia, inguinal, Edema, bilat	Unknown

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lawrence Lee Jr. M.D.
Address Balmore City Hosps. Date signed 4-4-47

VS 150

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G50722

BCH # 75726

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

✓ G50722 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 16th ST. & LAFAYETTE ST.
(c) Hospital or institution: HOSPITAL FOR WOMEN 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town — Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. — 2121 Harlent St
(If rural give location)
(e) Citizen of foreign country? K.D. (Yes or No)
If yes, name country —

3 (a) FULL NAME Baby Girl BRUNNER

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 4/11/47

8. AGE: Years	Months	Days	If less than one day
—	—	—	5 hr. 3 min.

9. Birthplace BALTIMORE, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name HOWARD BRUNNER
13. Birthplace BALTIMORE, Md.

MOTHER
14. Maiden Name THERALA CARTER
15. Birthplace PEMBROKE, NORTH CAROLINA

16 (a) Informant MOTHER
(b) Address —

17 (a) Removal (b) Date thereof 4/12/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory —
Location Johns Hopkins Medical School APR 14 1947

18 (a) Funeral director Commissioner of Health
(b) Address —

19 APR 15 1947 (Huntington Williams M.D.)
(Date rec'd by Registrar)

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/12/47 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/11/47 19 , to 4/12/47 19 , and that I last saw h.CR. alive on 4/12/47 19 .

Immediate cause of death	Duration
ATELECTASIS due TO PREMATURITY	
Due to —	
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature W. L. Summers M. D.
Address Women's Hospital Date signed 4/12/47

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G50723

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

131a ✓ Registered No. G50723

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1715 Montpelier St.
(c) Hospital or institution: 9-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 71-8-3

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1715 Montpelier St., (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Howard Armstrong

3 (b) If veteran, name war	3 (c) Social Security Account No.
---	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Agnes M. Armstrong
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 10, 1875

8. AGE: Years	Months	Days	If less than one day
71	8	34	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business Swindell Bros., Inc.

FATHER
12. Name James Armstrong
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine Burton
15. Birthplace Md.

16 (a) Informant Mrs. Agnes M. Armstrong
(b) Address 1715 Montpelier St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-17-47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore Co., Md.

18 (a) Funeral director J. Howard Strong
(b) Address 3207 W. North Ave.

19 (a) APR 15 1947 (Date received by Registrar) Registrar for Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1947, at 5:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1944, to April 14 1947, and that I last saw h alive on April 13 1947.

Immediate cause of death	Duration
(a) Chronic Interstitial Nephritis	3 yrs.
Due to (b) Endocarditis	3 yrs.
Due to (c)	
Other Conditions Hypertension Coagulation (Include pregnancy within 3 months of death)	1 day

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. H. Dady M. D.
Address 617 Medical Arts Date signed April 14 1947

X

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

C50724

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1223

Registered No. C50724

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use no abbreviations. If unknown, write the causes of death clearly and legibly. correct age is especially important. Physicians: please

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave. & Madison St.
(c) Hospital or institution: Maryland Gen'l Hosp. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3103 Presbury St.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura B. Colliflower

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Married.

6 (b) Name of husband or wife J. Edward.
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26, 1884

8. AGE: Years	Months	Days	If less than one day
62	8	16	hr. min.

9. Birthplace Matthews Co., Va.
(Town, county, and state)
10. Usual Occupation House-wife
11. Industry or business

FATHER
12. Name Charles Treakle
13. Birthplace Va.

MOTHER
14. Maiden Name Laura B. Richardson
15. Birthplace Va.

16 (a) Informant Mr. James E. Colliflower
(b) Address 3103 Presbury St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-15-47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn, Md.

18 (a) Funeral director H. Howard Strong
(b) Address 3207 W. North Ave.,

19 (Date rec'd by registrar) APR 15 1947 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 April 1947 at 8:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 April 1947 to 11 April 1947 and that I last saw her alive on 11 April 1947.

Immediate cause of death Respiratory Failure — Duration

Due to Post Operative Pneumonia —

Due to Operation - Anterior Gastro-Enterostomy —

Other Conditions Infected Abdominal Abstruction

(Include pregnancy within 3 months of death)

Date of operation 12-20-46.

Major findings of operation: Infected Abdominal Abstruction Adhesions.

of autopsy: Same.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ernest A. Cassano M. D.
Address Maryland Gen'l Hosp. Date signed 11 April 47

VS 150

G50725 LENA

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G50725

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1316 N. Milton Ave
(c) Hospital or institution: 6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town).
(d) Street No. 1316 N. Milton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME E. Louise Lenk

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ida Alvina Lenk

6 (c) If alive, give age 82 years

7. Birth date of deceased (mo., day, yr.) Oct. 3, 1860

8. AGE: Years 86 | Months 6 | Days 9 | If less than one day: hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation
11. Industry or business Retired

FATHER
12. Name Christian Gottlob Lenk
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Gottliet Pfeng
15. Birthplace Germany

16 (a) Informant Ida Alvina Lenk
(b) Address 1316 N. Milton Ave

17 (a) Burial (b) Date thereof 4-15-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Balto. Cem.
Location North Ave

18 (a) Funeral director John C. Miller Inc
(b) 2435 E. Oliver St

19 (d) APR 15 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-12 1947, at 12:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/30 1946 to 19, and that I last saw him alive on 4/11 1947.

Immediate cause of death	Duration
Coronary Sclerosis	?
Due to Arteriosclerotic Heart	
Due to disease	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Wm. Bauer
Address 1501 N. Milton Ave Date signed 4/14/47 M.D.

V S 150

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

50726

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C50726

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 439 N. Fergerson Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 439 N Fergerson Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin W. Johnson
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed or divorced. Married
6 (b) Name of husband or wife Josephine E. Johnson
6 (c) If alive, give age 48 years
7. Birth date of deceased (mo., day, yr.) July 13 1902
8. AGE: Years 44 Months 9 Days 1 If less than one day hr. min.
9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business Bethlehem Steel
12. Name Benjamin W. Johnson (FATHER)
13. Birthplace Balto. Md.
14. Maiden Name Laura L. Smith (MOTHER)
15. Birthplace Balto. Md.
16 (a) Informant Josephine E. Johnson
(b) Address 439 N Fergerson Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-17-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road
18 (a) Funeral director Riley & Miller
(b) Address 2435 E Oliver St
19 (a) APR 15 1947 (Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1947 at 7:15 A.M
21. I certify that death occurred on the date above stated; that I attended deceased from 12-23 1946 to 4-14 1947 and that I last saw him alive on 4-14 1947
Immediate cause of death Coronary Thrombosis — Duration 6 weeks
Due to Hypertension — 2 years
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Benj. B. Means M.D. M. D.
Address 448 N. Fergerson Ave Date signed 4-14-47

VS 150

X

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G50727

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G50727 Registered No.

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4402 Towanda Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4402 Towanda Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME IDA ELIZABETH EADER

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband ~~WIFE~~ Charles M. Eader
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 16, 1859

8. AGE: Years	Months	Days	If less than one day
88	0	26	7 hr. min.

9. Birthplace Frederick, Md.
(Town, county, and state)
10. Usual Occupation Home
11. Industry or business

FATHER
12. Name Emanuel Peter Mantz
13. Birthplace Frederick, Md.

MOTHER
14. Maiden Name Manzella Grove
15. Birthplace Md.

16 (a) Informant Mrs. Ida B. Burns, Daughter
(b) Address 4402 Towanda Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/15/47 (month) (day) (year)
(c) Cemetery ~~FRIENDSHIP~~ LOUDON PARK CEM.
Location Baltimore Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md.

19 APR 15 1947 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 12, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 3 1947 to Apr 12 1947 and that I last saw her alive on Apr 11 1947

Immediate cause of death	Duration
Pneumonia	
Due to	
Due to	
Other Conditions Fractured left shoulder Mar 3 1947 (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or ~~homicide~~ Mar 3. 47
(b) Date of occurrence March 3/947 at M
(c) Where did injury occur? 4402 Towanda Ave. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? at home While at work? no (Specify type of place)
(e) Means of injury Fell down stairs 15/13

23. Signature Earl L Royer M. D.
Address 701 Cathedral Date signed

X Earl L Royer M.D.

G50728

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 94a

G50728 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave.
(c) Hospital or institution:
Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1336 Crofton Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ReEtta Clementine Disney

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife: Francis P. Disney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan 15, 1861

8. AGE: Years	Months	Days	If less than one day
86	2	27	hr. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

MOTHER / FATHER
12. Name: David Gardner
13. Birthplace: Mass.

MOTHER
14. Maiden Name: Emily Laycock
15. Birthplace: Virginia

16 (a) Informant: Mrs. Helen Mitchell
(b) Address: 1336 Crofton Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Apr. 15, 1947 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore, Md.

18 (a) Funeral director: Wm. J. Tickner & Sons, Inc.
(b) Address: North & Pa. Aves.

19 (a) APR 15 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION A

20. DATE OF DEATH: April 12, 1947, at 6:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 16 1946 to April 12 1947 and that I last saw h[illegible] alive on April 7 1947.

Immediate cause of death: Coronary Occlusion — Duration: 1 hr.
Due to:
Due to: Parkinson's Disease — Duration: Indefinite
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:
23. Signature: Patrick Dee, M.D.
Address: 1130 W. 36 St. Date signed: 4/14/47

VS 150

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G50729

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Register No. G50729

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2558 EDMONDSON AVE
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 60 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2558 EDMONDSON AVE
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME KATHLEEN BOWMAN FRUSH

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	WIDOWED

6 (b) Name of husband or wife GILBERT VAN DORN VOORHEES
JOHN SNYDER FRUSH 6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) MAR 14 1864

8. AGE: Years	Months	Days	If less than one day
83	0	29	— hr. — min.

9. Birthplace FLAGTOWN, N.J. (Town, county, and state)
10. Usual Occupation H.W.
11. Industry or business NONE

FATHER
12. Name HUGH YOUNG
13. Birthplace IRELAND

MOTHER
14. Maiden Name LILIAN CARR
15. Birthplace IRELAND

16 (a) Informant DAUGHTER, JANE McCLAVE
(b) Address 296 KNOX AVE; GRANTWOOD, N.J.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/16/47 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (c) APR 15 1947 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 13 1947, at 3:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from APRIL 6 1947, to APRIL 13 1947, and that I last saw her alive on APRIL 12 1947.

Immediate cause of death: CEREBRAL ARTERIO SCLEROSIS — Duration: 2

Due to

Due to

Other Conditions GENERAL SENILITY

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John M. Lord M. D.
Address 8 Longwood Rd Date signed APR 13

PLEASE WRITE PLAINLY, WITH UNFADING INK. Erase or write over. Do not abbreviate. Write the causes of death clearly and legibly. Give correct age in years, months, days, hours, or minutes. Physicians: please write carefully. Every item is especially important.

VS 150

X

G50730

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G50730

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4140 Roland Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4140 Roland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LEWIS B. TAYLOR

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Margaret Ellen Taylor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1863

8. AGE: Years	Months	Days	If less than one day
83	11	1	hr. min.

9. Birthplace Walkersville, Md.
(Town, county, and state)
10. Usual Occupation Agent (retired)
11. Industry or business U. S. Express Co.

FATHER
12. Name John Taylor
13. Birthplace Va.

MOTHER
14. Maiden Name - Barrick
15. Birthplace Va.

16 (a) Informant Mr. John L. Taylor
(b) Address 4140 Roland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/16/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 APR 15 1947 (b) Huntington Williams, M.D.
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13, 1947 at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 1946 to April 13 1947 and that I last saw him alive on April 12 1947.

Immediate cause of death	Duration
Terminal Hypostatic Pneumonia	3 days
Due to Metastasis Thrombi Aorta	5 weeks
Due to Senile Arteriosclerosis & Myocardial Degeneration	1 year
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elliot W. Johnson M.D.
Address 343 Druid Ave Date signed

VS 150

Please write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

G50731

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G50731

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3029 Presstman St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3029 Presstman St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorcilla E. Langley

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Edwin Langley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 28, 1869

8. AGE: Years	Months	Days	If less than one day
77	5	15	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name James P. Townsend
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Cecalia ?
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Gladys C. Bohmer
(b) Address 1052 Hegeman St., Schenectady, N.Y.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/16/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Maryland

19 (a) APR 15 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

correct age is especially important

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 April 1947, at 10 A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammerer Jr., M.D.
Medical Examiner.
Date signed 13 April 47

VS 151

X

G50732

AB-92406

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G50732

Registered No.

PLEASE WRITE PLAINLY, with unfading ink. Fill all blanks. Be sure the causes of death clearly and legibly. correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2yrs- 1mo-7days
(e) Length of stay in Baltimore (yrs., mos., or days) 22yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 125 S. Bond Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Brown

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	Married

6 (b) Name of husband or wife Queen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 13-1881 Aug. 18-1881-or

8. AGE:	Years	Months	Days	If less than one day
or	65 65	7 7	29 24	hr. min.

9. Birthplace Ga.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name	Jabus Brown (D
FATHER 13. Birthplace	Ga.
MOTHER 14. Maiden Name	Rhoda McKinney (D
MOTHER 15. Birthplace	Ga.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 16 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Baltimore Md.

18 (a) Funeral director Robert L. Young Jr.
(b) Address 1246 N. Caroline St.

19 (a) APR 15 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION PM

20. DATE OF DEATH April 12 1947, at 6.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-5- 1945, to 4-12 1947, and that I last saw him alive on 4-12- 1947.

	Duration
Immediate cause of death Pulmonary Hemorrhage.	
Due to Carcin. Thr.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert A. Farber M. D.
Address Balto City Hosps Date signed 4-13-47

VS 150

G50733

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G50733

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 38 E. Churchill St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 38 E. Churchill St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mattie Austin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced widowed

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years 47 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Balto md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Dick Brown Son
(b) Address 108 W. Montgomery St

17 (a) Burial (b) Date thereof 4-15-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto City

18 (a) Funeral director Isaiah S. Brown Son
(b) 1947 Montgomery St

19 (a) APR 15 1947 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 | 11 | 1947, at 2:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 | 15 | 1947, to 4 | 11 | 1947, and that I last saw h[illegible] alive on 4 | 8 | 1947

Immediate cause of death Pulmonary T.B. — Duration 2 years
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 4 Dow Bell St. Date signed 4/14/47

PLEASE WRITE PLAINLY. Fill in the causes of death correctly and legibly. Physicians: please write the correct age is especially important.

VS 180

0734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G50734
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use typewriter if possible. Do not abbreviate. Write the cause of death clearly and legibly. Give full name of deceased. If not in hospital or institution, give residence. Do not use initials but write out full name of street and number. Give correct age in years, months, days. If less than one day, give hours or minutes. Physicians: please write plainly. Your certificate is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1301 Park Ave.
(c) Hospital or institution: Nursing Home 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 744 Reservoir St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Munder Thomas

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Herbert Thomas
6 (c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.) March 26 1861

8. AGE: Years 86 | Months 0 | Days 18 | If less than one day: hr. ____ min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation none
11. Industry or business none

FATHER
12. Name Charles F. Munder
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Priscilla R. Price
15. Birthplace Alex. Va.

16 (a) Informant Mrs Geo R. Vickers-3rd (daughter)
(b) Address 222 W Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 15 47 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore

18 (a) Funeral director Stuart Morrow Co.
(b) Address 108 W North Ave.

19 APR 15 1947 (b) Huntingtown Millington, Md
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1947 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1946 to April 13 1947.
and that I last saw her alive on April 12 1947.

Immediate cause of death: Coronary Thrombosis
Due to: Myocarditis
Arterio Sclerosis
Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:

of autopsy:

Duration: One day — Gradual ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. P. Hardy M. D.
Address 1403 Park Ave Date signed 4/15/47

VS 150

X

50735

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G50735 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use the cause of death clearly and legibly. Give correct age in especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2717 St Paul St -
(c) Hospital or institution: at home 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2717 St Paul St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Emily Oliver Barton

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife Single
6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) Dec 5 1865

8. AGE: Years	Months	Days	If less than one day
81	4	8	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation none
11. Industry or business none

FATHER
12. Name Philip Alex. Barton
13. Birthplace Baltimore

MOTHER
14. Maiden Name Anna M. F. Oliver
15. Birthplace Baltimore

16 (a) Informant Miss Eliza Lee Barton (Sister)
(b) Address 2717 St Paul St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 15 47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director Stewart Mamula
(b) Address 1084 W Fort Ave.

19 APR 15 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10, 1946 to April 13, 1947 and that I last saw him alive on April 13, 1947

Immediate cause of death	Duration
Coronary Thrombosis	Immediate
Due to Coronary Arteriosclerosis	over 6 mos.
Due to	
Other Conditions Hypertension.	over 6 mos.

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide -
(b) Date of occurrence - at - M
(c) Where did injury occur? - - -
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? - While at work? -
(Specify type of place)
(e) Means of injury

23. Signature Frank H. Ogden M. D.
Address 2701 N. Calvert St. Date signed Apr. 14, 47

VS 150

50736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50736

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2520 Madison Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2520 Madison Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Peter C. Blake

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Mary L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7, 1885

8. AGE: Years 62 | Months 1 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Custodian

11. Industry or business

FATHER
12. Name Peter C. Blake
13. Birthplace Va

MOTHER
14. Maiden Name Lydia Wilson
15. Birthplace Balto. Md.

16 (a) Informant Eugene Bernard Blake
(b) Address 2067 McCulloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-15-1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Thos. George A. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) APR 15 1947 (Registrar) Huntington Williams (Registrar) M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/10/47 19..., at 8 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-10-1947 to 19..., and that I last saw h... alive on 19...

Immediate cause of death: Cerebral Hemorrhage — Duration: 1 hr

Due to:

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: None

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hawkes Cowe M. D.
Address 1131 Hanlon Date signed 4/14/47

PHYSICIAN
Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Be sure that correct age is especially important.

VS 150

G50737 G50737

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4915 Midwood Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 11 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4915 Midwood Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Friedrich Max Bachmann

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Elizabeth I.
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Apr 22 1886

8. AGE: Years	Months	Days	If less than one day
60	11	9 21	hr. min.

9. Birthplace Dresden Saxony Germany
(Town, county, and state)

10. Usual Occupation Mechanical Draftsman

11. Industry or business —

FATHER
12. Name Wilhelm Bachmann
13. Birthplace Dresden Saxony Germ

MOTHER
14. Maiden Name Helene Bauchel
15. Birthplace Dresden Saxony Germ

16 (a) Informant Wife Elizabeth I Bachm
(b) Address 4915 Midwood Ave

17 (a) Cremation (b) Date thereof Apr. 16 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location 3201 Frederick Rd

18 (a) Funeral director Harry H. Mitchell
(b) Address 4101 Edmondson Ave

APR 15 1947 (Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 April 1947 at 3 27 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10 March 1947 to 13 Apr 1947, and that I last saw h.im alive on 13 Apr 1947

Immediate cause of death: Cerebral Embolism — Duration: 4 days

Due to Congestive Heart Failure & Auricular Fibrill. — 33 days

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Adams M.D.
M. D.

Address 5602 Harford Rd Date signed 13 Apr 47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Be sure the cause of death clearly and legibly. Statements are especially important. Physicians: please write the

G50738

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G50738 Registered No. 83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 507 Old Orchard Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 507 Old Orchard Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William S. J. Peregoy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lavinia E.
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 1, 1867

8. AGE: Years	Months	Days	If less than one day
79	5	11	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Mechanical Engineer
11. Industry or business Retired

FATHER
12. Name John T. Peregoy
13. Birthplace Md/

MOTHER
14. Maiden Name Elizabeth Sterling
15. Birthplace Md.

16 (a) Informant Mrs. Lavinia S. Peregoy
(b) Address 507 Old Orchard Rd.

17 (a) Burial (b) Date thereof April 16/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Rd.

18 (a) Funeral director Harry H. Smith
(b) Address 4101 Edmondson Ave.

19 (a) 1947 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1947, at 11.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 5 1947, to April 12 1947, and that I last saw him alive on April 12 1947

Immediate cause of death	Duration
Cerebral Hemorrhage	7 days
Due to Arteriosclerosis	
Due to	
Other Conditions Terminal Bronchopneumonia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Vernon H. Norwood
Address 5101 Woodside Rd. Date signed April 14

PLEASE WRITE PLAINLY. Use ink. Do not use pencil. Be sure the causes of death are clearly and legibly stated. Physicians: please write the causes of death clearly and legibly. Omissions are especially important.

G50739

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

G50739 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Idlewood & Greene
(c) Hospital or institution: Univ. Hosp. 2 Wd
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Wd
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2800 Sunset Dr
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Hyser Mary A Hyser

3 (b) If veteran, name of war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Charles L
6 (c) If alive, give age L years

7. Birth date of deceased (mo., day, yr.) Jan 2, 1890

8. AGE: Years	Months	Days	If less than one day
57 58	3	10	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John B Faherty
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Anna Gardner
15. Birthplace Balto. Md

16 (a) Informant Charles L Hyser
(b) Address 2800 Sunset Dr

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Apr 16 '47 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location 3801 Frederick Rd

18 (a) Funeral director Henry A Wetzler
(b) Address 4101 Edmondson Ave

19 (a) Filed by registrar (b) Huntington Williams

PR 15 1947
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-4-47 19 to 4-12 1947 and that I last saw h[illegible] alive on 4-12 1947

Immediate cause of death	Duration
Pulmonary Tb	
Due to	
Due to	over
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [illegible] M. D.
Address [illegible] Date signed 4-[illegible]-47

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

G50740

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G50740 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: General Sessons aged People Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 22 Athol Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Philomena Schaum

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ late Benjamin Schaum
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 17 1861

8. AGE: Years	Months	Days	If less than one day
86	1	26	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Nicholas Weller
13. Birthplace Germany

MOTHER 14. Maiden Name Philobeta Lipps
15. Birthplace Germany

16 (a) Informant General Sessons Aged People Home
(b) Address 22 Athol Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 15 '47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave

18 (a) Funeral director Harry H Wright
(b) Address 4101 Edmondson Ave

19 (a) (Signature of undertaker) Huntington Williams
(b) Address

APR 15 1947

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MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 3/47 to Apr. 13/47 and that I last saw h 6r alive on Apr. 6/47.

Immediate cause of death	Duration
Possible cancer of liver	Unknown
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Henry Harvey Chaillé M. D.
Address 933 Hanover St. Date signed Apr. 14 47.

PLEASE WRITE PLAINLY. Give the causes of death clearly and accurately. Physicians: please write the correct age in years, months and days. Be especially important.

X

G50741

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/X 50

G50741 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert.
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 months
(e) Length of stay in Baltimore (yrs., mos., or days) 7 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Indiana (b) County
(c) City or town Evansville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Cambridge Arms Apts
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME NITA R. CLEVELAND

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife DR WALTER CLEVELAND
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 22, 1883

8. AGE: Years	Months	Days	If less than one day
63	8	21 2/3	hr. min.

9. Birthplace INDIANA
(Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name FRANK RICHARDS
13. Birthplace GERMANY

MOTHER
14. Maiden Name LOUISE FERTIG
15. Birthplace UNKNOWN

16 (a) Informant Jackson Kidd Jr
(b) Address 110 Cathedral Rd

17 (a) Removal (b) Date thereof April 16-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Crawfordsville Indiana

18 (a) Funeral director Henry F Wyche
(b) Address 4101 Edmondson Ave

19 (a) (b) Date signed (Month) (Day) (Year)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 14 1947, at 7:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947, to April 14 1947, and that I last saw h.er alive on April 14 1947.

Immediate cause of death	Duration
Cerebral embolism	1 hour
Due to Coalescing sclerotic Heart Disease	8 years
Due to	
Other Conditions Carcinoma of breast with metastasis to spine (Include pregnancy within 3 months of death)	

Date of operation JAN 17, 1944
Major findings of operation: Scirrhous Carcinoma breast
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Joseph C. Beatty M. D.
Address Union Mem Hosp. Date signed April 14 1947

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and correct age is especially important.

G50742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G50742 Registered No. [redacted]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Hospital 51
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 278 N. Exeter St
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Ernest White

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Sep

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years	Months	Days	If less than one day
76			.....hr. .....min.

9. Birthplace Venton md
(Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER 12. Name	Harriet White
13. Birthplace	Venton md
MOTHER 14. Maiden Name	Henrietta Pivlet
15. Birthplace	Venton md

16 (a) Informant Virginia [illegible] Venton
(b) Address Venton md
17 (a) Burial (b) Date thereof April 15, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn md
18 (a) Funeral director Elroy O. Wilson
(b) Address 1005 Baltimore ave
19 1947 Date rec'd by r[illegible] Huntington Williams MD Registrar

VS 151

Correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/11 1947, at 6:30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. disease

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature A. J. Gabrielski M.D.
Medical Examiner.
Date signed 4/12/47

X

G50743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

G50743
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 612 N. Stockton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PHIL PULLEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	married

6 (b) Name of husband or wife Rachel Pulley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 19, 1901

8. AGE: Years	Months	Days	If less than one day
46	2	23	hr. min.

9. Birthplace A. A. County, Md.
(Town, county and state)
10. Usual Occupation Stevedore
11. Industry or business

FATHER
12. Name Jacob Pulley
13. Birthplace A. A. County, Md.

MOTHER
14. Maiden Name Cynthia Wright
15. Birthplace A. A. County, Md.

16 (a) Informant Rachel Pulley
(b) Address Arnold, A. A. Co. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-17-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Arnold, A.A. Co. Md.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D.

APR 13 1947

VS 191

correct age is especially important. Physicians, please write plainly.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11, 1947, at 11:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wounds of chest involving right lung, Bullet wound of left mandible

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-11-47 at 11:30 P.M.
(b) Where did injury occur? 760 Vine Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearms

23. Signature Earl L Royer M.D.
Medical Examiner

Date signed 4-12-47

G50744

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a

Registered No. G50744

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 405 N. Schroeder St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 405 N. Schroeder St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hannie Taylor.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race C

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Allen Taylor.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6, 1907.

8. AGE: Years 40 Months ~ Days 7 ~ If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Charles E. Johnson.
13. Birthplace Chestertown, Md.

MOTHER
14. Maiden Name Susan Thomas.
15. Birthplace Baltimore, Md.

16 (a) Informant Annie Shippard.
(b) Address 1036 W. Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-17-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (b)
(Date received by registrar)

APR 15 1947 Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/13 1947, at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/12/46 19 to 4/13/47 19, and that I last saw her alive on 4/10/47 19.

	Duration
Immediate cause of death Carcinoma of Cervix (Epidermoid Cell)	
Due to Metastasis.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jno. A. Duleque Jr. M. D.

Address 511 N. Fulton Ave. Date signed 4/16/47

X

PLEASE WRITE PLAINLY. Fill in the causes of death clearly and legibly. Give correct age is especially important. Physicians: please write the

PONCIA

G50745

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

Registered No. G50745

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 929 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Poncia

3 (b) If veteran, name war

3 (c) Social Security Account No. 231-01-6464

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. 1

6 (b) Name of husband or wife Gladys U Poncia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-29-74

8. AGE: Years 72 | Months 6 | Days 15 | If less than one day hr. min.

9. Birthplace Buenos-Aires (Town, county, and state)

10. Usual Occupation Ship Chandler

11. Industry or business

FATHER 12. Name ?

13. Birthplace ?

MOTHER 14. Maiden Name ?

15. Birthplace ?

16 (a) Informant Jack Migliorelli

(b) Address 105 S. Broadway St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-16-1947 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belgian Rd. Frank Della Ratta

18 (a) Funeral director

(b) Address 52 N. Wesley St.

19 (Date rec'd by registrar) APR 15 1947 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1947 at 8:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-17- 1947 to 4/13 1947 and that I last saw h[illegible] alive on 4/13 1947

Immediate cause of death — Duration

Uraemia

Due to Carcinoma

Due to of Prostate

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.

Address 16 S. Hoyt Date signed 4-12-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

VS 150

MEETh

G50746

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G50746 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette Boyd St
(c) Hospital or institution Bon Secours Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 115 S. Hilton ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs. Meeth Ann Rebecca Meeth

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife John T. Meeth

6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) May 9, 1895

8. AGE: Years 56 | Months 11 | Days 13 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Felix McCurley
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Ella Shepherd
15. Birthplace Baltimore

16 (a) Informant John T. Meeth
(b) Address 115 S. Hilton ave Catonsville

17 (a) Burial (b) Date thereof 4-16-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Fred A. Poles
(b) Address 1000 Fountain St

19 (APR 15 1947) Huntington Mills Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1947, at 11:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/3 1947, to 4/12 1947, and that I last saw h.R.R. alive on 4/12 1947.

Immediate cause of death Respiratory failure

Due to Cerebrovascular accident

Due to Hypertension.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation N.H.G.

Major findings of operations

of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James Alt Wardy M. D.

Address Bon Secours Hospital Date signed 4/13/47

PLEASE WRITE plainly. Please write the causes of death clearly and correct age is especially important. Physicians: please

G50747

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45F

G50747 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Give the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1922 E Lafayette Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DEACEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits write RURAL and give town)
(d) Street No. 1922 E Lafayette Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Armstrong

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-07-8146

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 7th 1867

8. AGE: Years 79 | Months 5 | Days 6 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Md. Brassiere Co.

FATHER
12. Name Wm. Armstrong
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Eliza Espey
15. Birthplace Not Known

16 (a) Informant Mrs. C. Schumacher
(b) Address 1922 E. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/16/47 (month) (day) (year)

(c) Cemetery or crematory Mt. Carmel
Location Balto. Md.

18 (a) Funeral director C. D. Fanning & Son
(b) Address 1938 E. Lafayette Ave.

19 APR 15 1947 (Date received by registrar) Huddington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 13th 1947, at 11 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 14 1946 to April 13 1947.
and that I last saw h. alive on April 12 1947

Immediate cause of death Carcinoma of Uterus

Due to Cachexia and Metastases

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration 7 months 1 day

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert C Schumacher M. D.
Address 2052 North Ave Date signed 4-14-47

G50748

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Register No. G50748

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3414 Alto Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3414 Alto Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUISA AUGUSTA MULLER

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NONE

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 30, 1867

8. AGE: Years 79 | Months 4 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Christian Muller
13. Birthplace Germany

MOTHER
14. Maiden Name Eva Miller
15. Birthplace Germany

16 (a) Informant Miss Emma Muller
(b) Address 3414 Alto Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/16/47 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK CEMETERY
Location BALTIMORE, MARYLAND

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) APR 15 1947 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1947, at 8 05 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/5 1946 to 4/13 1947, and that I last saw her alive on 4/13 1947.

Immediate cause of death	Duration
Myocardial Insufficiency	2 days
Due to Senility	—
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert A. Reiter, M.D.
Address 340 W Windsor Ave Date signed 4/17/47

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Accurate and correct age is especially important.

VS 150

G50749 M 75679

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G50749

PLEASE WRITE PLAINLY, with ink. Physicians: please write the causes of death clearly and legibly. Use only standard abbreviations. Do not use ditto marks. Be sure that the answer to each question is complete and correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Williams & Caton Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write R.F.D. and give town)
(d) Street No. 521 W. Holly Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Annacone

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/13/47

8. AGE: Years | Months | Days | If less than one day: hr. 25 min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Raymond Annacone
13. Birthplace Va.

MOTHER — 14. Maiden Name Donna Annacone
15. Birthplace Va.

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-15-47 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore

18 (a) Funeral director George A. Fraley

(b) Address 1600 Block E. Fayette St.

19 (a) APR 15 1947 (Date rec'd by Registrar) Signature for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/13 1947, at 3:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/13 1947 to 4/13 1947, and that I last saw h[illegible] alive on 4/13 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Prematurity - 5½ months	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: none performed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Peter H. Lincke M.D.

Address St. Agnes Hosp. Date signed 4/14/47

G50750

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G50750

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use typewriter if possible. Do not abbreviate. Write the causes of death clearly and legibly. Give full name of deceased. If female, give maiden name. Give correct age in years, months, days, hours, or minutes. Underlining is especially important. Physicians: please write your diagnosis.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4017 Halsdale Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Balt.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4017 Halsdale Ave.
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Anna C. Hatzfeld

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/18/1886

8. AGE: Years	Months	Days	If less than one day
60 61	10	5	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name John Hatzfeld
13. Birthplace Germany

MOTHER
14. Maiden Name Theresa Deimler
15. Birthplace Md.

16 (a) Informant H. L. Auer
(b) Address 4 Wallenford Ave

17 (a) Burial (b) Date thereof 4-17-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Baltimore

18 (a) Funeral director George Foley
(b) Address Fulton Ave & Fayette St

19 (Date rec'd by registrar) APR 15 1947 Thurlington for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1947 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1 1947 to April 13 1947, and that I last saw h[illegible] alive on April 12 1947.

Duration

Immediate cause of death Cerebral Hemorrhage
Due to Hypertension
Due to Arteriosclerosis
Other Conditions Myocarditis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert C. Hatzfeld M. D.
Address 2151 Walbrook Ave Date signed 4/15/47

VS 150

G50751

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Register No. G50751

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use the space for the cause of death clearly and legibly. Be sure that the correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs. 45 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 928 Argyle Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lawrence L. Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	N	Married

6 (b) Name of husband or wife Sarah Grimes Jackson.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 15, 1907

8. AGE: Years	Months	Days	If less than one day
39	6	29	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Eugene Jackson.
13. Birthplace Fredericksburg Va.

MOTHER
14. Maiden Name Sadie M. Gross.
15. Birthplace Baltimore, Md.

16 (a) Informant Eugene D. Jackson.
(b) Address 1928 Argyle Ave.

17 (a) Burial (b) Date thereof 4-18-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mr Katie R. Williams
(b) Address 3227 Schroeder St
19 APR 15 1947 Huntington Williams Mgr
(Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/14 1947 at 5:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/14 1947, to 4/14 1947, and that I last saw h/e alive on 4/14 1947.

Immediate cause of death	Duration
Pulmonary Edema	
Due to Congestive Heart Failure	2 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [illegible] M. D.
Address Rancocas Jobs Date signed 4/16/47

G50752

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G50752

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Kent
(c) City or town Rock Hall
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert C. URIE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Julia W. Urie
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years 54 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Samuel Urie
13. Birthplace Kent Co

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant Hospital
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 17-47 (month) (day) (year)
(c) Cemetery or crematory Wesley Chapel
Location Rock Hall Md

18 (a) Funeral director Clifton L. Lane
(b) Address Chestertown Md

19 (a) APR 15 1947 (Date rec'd by registrar) (b) Huntington Williams MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 April 1947, at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1 April 1947, to 14 Apr 1947, and that I last saw h[illegible] alive on 14 Apr 1947.

Immediate cause of death Toxemia due to extensive 2nd & 3rd° Burns — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide fell into fire (trash)
(b) Date of occurrence 31 Mar 47 at ? M
(c) Where did injury occur? Rock Hall - Kent Co Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Means of injury Burns - fire in a trash can.

23. Signature R. E. Bauer

Address Univ. Hosp. Date signed 14 Apr 47

Earl L Royer, M.D.

VS 150

PLEASE WRITE PLAINLY, with ... correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50753 BC# 575887 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 159 G50753 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave 16
(c) Hospital or institution: West Balto Gen Hosp - 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto 16
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1014 Warwick Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Schlee

3 (b) If veteran, name war none

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-11-47

8. AGE: Years	Months	Days	If less than one day
			23 hrs 49 min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name William Schlee

13. Birthplace Balto Md.

MOTHER 14. Maiden Name Louise Hoffman

15. Birthplace Balto Md.

16 (a) Informant

(b) Address 1014 Warwick Ave 16

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory University Medical School

Location Commissioner of Health APR 14 1947

18 (a) Funeral director

(b) Address

19 APR 15 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1947 at 2.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/11 1947 to 4-12 1947 and that I last saw him alive on 4-12 1947.

Immediate cause of death Prematurity — Duration 1 day

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Subcapsular hemorrhage

of autopsy Liver, Spleen, Kidneys

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman A Klemm

Address 3403 Edmondson Ave Date signed M. 4/13/47 D.

PLEASE WRITE PLAINLY with pen and ink. Write the causes of death clearly and legibly. Physicians: please write the correct age in years, months, days, hours, or minutes. Physicians; please write the correct age is especially important.

VS 150

G50754

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G50754 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2234 Sidney Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 51
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2234 Sidney Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha M. March

3 (b) If veteran, name war	3 (c) Social Security Account No.
N	[illegible]

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ Philip March
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 18th 1881

8. AGE: Years	Months	Days	If less than one day
65	6	26	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER	12. Name Jacob Schmidt
	13. Birthplace Germany
MOTHER	14. Maiden Name Elizabeth Wolfe
	15. Birthplace Germany

16 (a) Informant Louise Pardoe
(b) Address 2604 Smith Ave

17 (a) Burial (b) Date thereof 4/17/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

(c) [illegible] 1947 (Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14th 1947, at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1945 to April 14, 1947, and that I last saw h[illegible] alive on April 14 1947.

Immediate cause of death Coronary Thrombosis — Duration 3 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Schofield M.D.
Address 701 Aisquith Date signed 4/15/47

PLEASE WRITE PLAINLY, with pen and ink. Fill in all blanks by typewriting or printing. Be sure to state the causes of death clearly and accurately. Use correct age in especially important. Physicians: please write the

G50755

BALTIMORE CITY HEALTH DEPARTMENT ✓ G50755 Registered No.

CERTIFICATE OF DEATH 83a 314

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3324 W. Belvedere Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3324 W. Belvedere Ave (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary E. Williams

3 (b) If veteran, name war	3 (c) Social Security Account No.
N	NONE

4. Sex	5. Color or race	6. (a) ~~Single~~, married, ~~widowed, or divorced~~
Female	White	Married

6 (b) Name of husband or wife Edmund Williams
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Feb 1st 1884

8. AGE: Years	Months	Days	If less than one day
63	2	12	..... hr. ..... min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Louis Dezmo
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Elizabeth Murphy
15. Birthplace Balto. Md.

16 (a) Informant Edmund Williams
(b) Address 3324 W. Belvedere Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 4/16/47 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Druid Ridge
Location Pikesville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) ..... (b) .....
(Date received by registrar) Registrar

APR 18 1947

VS 150

Information from Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13th 1947, at 4 07 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 9 1947 to April 13 1947 and that I last saw her alive on April 13 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	3 days
Due to Arterial Hypertension	2
Due to Arterio Sclerosis	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature E. E. Nichols M.D.
Address Pikesville Md Date signed 4-14-47

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

G50756

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G.50756
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3556 Sixth St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3556 Sixth St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Wilson

3 (b) If veteran, name war: W
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jeanette B. Wilson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23, 1881

8. AGE: Years	Months	Days	If less than one day
65	10	20	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name William C. Wilson
13. Birthplace Unknown

MOTHER
14. Maiden Name Eugene Betts
15. Birthplace Unknown

16 (a) Informant John J. Wilson
(b) Address 3556 Sixth St.

17 (a) Burial (b) Date thereof April 16, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Patapsco Highway B.O. Co.

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul St.

19 (a) (b)
(Signature of registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/13 1947, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1940 to April 13 1947.
and that I last saw h[illegible] alive on Feb 28 1947.

Immediate cause of death	Duration
Acute Coronary Occlusion	15 min.
Due to Arteriosclerotic Cardio-Vascular Disease	7 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Luttrell, M. D.
Address 320 Overyard Ave. Date signed 4/14/47

PLEASE WRITE PLAINLY. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

Huntington Williams, MD

X

G50757

CWK-106299

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G50757 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4- 20-
(e) Length of stay in Baltimore (yrs., mos., or days) 86- 6- 5-

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2910 Grantley Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Berryman

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife: Francisanna Berryman
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) October 2, 1860

8. AGE: Years	Months	Days	If less than one day
86	6	5	hr. min.

9. Birthplace Maryland (City, county, and state)
10. Usual Occupation Electrician
11. Industry or business Retired

FATHER
12. Name Errifan Berryman
13. Birthplace Virginia

MOTHER
14. Maiden Name Rohda Hanson
15. Birthplace Virginia

16 (a) Informant Balto. City Hospitals-Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-16-47. (month) (day) (year)
(c) Cemetery or crematory Asbury M.E. Cemetery
Location Reisterstown, Maryland

18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Ave.

19 (a) (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 19 47, at 10:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 22 1946, to Apr. 12 19 47, and that I last saw h[illegible] alive on Apr. 12 19 47.

Immediate cause of death	Duration
Coronary Occlusion	5 min.
Due to Interiocalcuratic Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marvin M. Lacy, M. D. M. D.
Address Baltimore City Hosp. Date signed 4-14-47

PLEASE WRITE PLAINLY, with ... correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

0758

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G50758

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6028 Old Harford Rd.
(c) Hospital or institution: 916

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1635 Broadway.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lina V. Smith

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Albert W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1867

8. AGE: Years	Months	Days	If less than one day
79	9	29	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name John W. Dix
13. Birthplace Va.

MOTHER
14. Maiden Name Annie Bloxom
15. Birthplace Va.

16 (a) Informant Albert E. Smith
(b) Address 3214 Overland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/16/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 APR 16 1947 (Date received by Registrar) (Signature of Registrar) Huntington for Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/13 1947, at 4.55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1946, to April 13 1947, and that I last saw h[illegible] alive on April 13 1947.

Immediate cause of death	Duration
Hypertensive Cardio Vascular Disease	
Due to Arteriosclerosis	
Due to	
Other Conditions Chronic Glomerulo Nephritis (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Laurence C. Post M.D. M. D.
Address 6805 York Road Date signed 4/15/47

PLEASE WRITE PLAINLY, with ink. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

X

759

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

Registrar's No. G50759

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 111 Riverside Rd. 25-4
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 111 Riverside Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George H. Arnold

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	widowed

6 (b) Name of husband or wife Effie F Arnold - Bullock
(c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Feb 9, 1862

8. AGE: Years	Months	Days	If less than one day
83 84	2	2	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business none

FATHER 12. Name George W. Arnold.
13. Birthplace Md.

MOTHER 14. Maiden name Jannetta Gardner.
15. Birthplace Md.

16 (a) Informant Elmer A. Arnold
(b) Address 111 Riverside Rd.

17 (a) Burial (b) Date thereof 4/11/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd

18 (a) Funeral director Thos F Dempsey Inc
(b) Address 614 Light St.

APR 16 1947 (b) Huntington Williams M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1947 at 9 15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 8 1947 to April 1947 saw h[illegible] alive on Apr 11 1947.

Immediate cause of death	Duration
Acute Dilatation of Heart	3 Hrs.
Due to Chronic Nephritis	Duty.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. L. Campbell M.D.
Address 1644 Hanover St Date signed 4/15/47

PLEASE WRITE PLAINLY. Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

0760

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

111c

G50760
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1603 W. Lexington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1603 W. Lexington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Mitchell

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Fannie Mithhell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 25, 1899?

8. AGE: Years	Months	Days	If less than one day
48	1	18 17	hr. min.

9. Birthplace South Caroline
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace S. C.

MOTHER
14. Maiden Name Not Known
15. Birthplace S. C.

16 (a) Informant Mrs. Fannie Mitchell
(b) Address 1603 W. Lexington St.

17 (a) Burial (b) Date thereof 4-16-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

(a) Date received by registrar APR 16 1947 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12, 1947 at 11:10

21. I certify that death occurred on the date above stated; that I attended deceased from April 7 1947 to April 12 1947 and that I last saw h. alive on April 7 1947

Immediate cause of death Hypostatic Pneumonia

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

Duration
4 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ralph W. Kelly Jr.
Address 415 N. Wyoming Date signed 4/23/47

PLEASE WRITE CLEARLY. Physicians: please write the causes of death correct are especially important.

0761 BC# B-71510 BALTIMORE CITY HEALTH DEPARTMENT ✓ G50761
CERTIFICATE OF DEATH 30F Registered No.

PLEASE WRITE PLAINLY, with pen or pencil. Physicians: please write the causes of death clearly and correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto City (If outside city or town limits, write RURAL and give town)
(d) Street No. 67 W Cross St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Josephine Thompson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: S.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/23/47

8. AGE: Years | Months: 1 | Days: 4 2 19 | If less than one day: hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER — 12. Name Moses Thompson
13. Birthplace S C

MOTHER — 14. Maiden Name Ida Parun
15. Birthplace S. C

16 (a) Informant Ida Thompson
(b) Address 167 W Cross St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-16-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Balto City

18 (a) Funeral director Isaiah L. Brown
(b) Address 105 W Montgomery St

19 (a) APR 16 1947 (b) [illegible] Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-14 1947, at 5 30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-8 1947, to 4-14 1947, and that I last saw her alive on 4-14 1947.

Immediate cause of death: Congenital Syphilis — Duration: 6 Wks
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Congenital Syphilis

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gerald A. Martin
Address Univ. Hospital Date signed M. D. 4-14-47

PHYSICIAN
Underline the cause to which death should be charged statistically.

VS 150

50762

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. C50762

PLEASE WRITE PLAINLY, with ink. Physicians: please write the causes of death clearly and legibly. Be sure that the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1021 Darley Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1021 Darley Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Annie E. Sullivan.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1871

8. AGE: Years	Months	Days	If less than one day
75	11	1	hr. min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation Housework.
11. Industry or business

FATHER
12. Name George Sullivan.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Elizabeth Bankert.
15. Birthplace Maryland.

16 (a) Informant Harvey O. Weant.
(b) Address 1021 Darley Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 16/47 (month) (day) (year)
(c) Cemetery or crematory Kriders
Location Westminster, Carroll Co. Md.

18 (a) Funeral director Chenoweth & Donovan.
(b) Address 3615 17 Chestnut Ave.

19 APR 16 1947 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1930 to April 13 1947. and that I last saw her alive on April 13 1947

Immediate cause of death: Cerebral hemorrhage

Due to: Hypertension and arteriosclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jack J. Singer, M.D.

Address 506 E. Hoffman Ave. Date signed 4/15/47

X

G50763

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

G50763 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp. 22nd
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 Ds.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Roland Park Apts. 4-5 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louise L. Harding

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Merville L. Harding
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 10, 1877

8. AGE: Years	Months	Days	If less than one day
70	1	5	hr. min.

9. Birthplace Georgia (Town, county, and state)
10. Usual Occupation None.
11. Industry or business

FATHER
12. Name Bascom Lowrey
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant John L. Harding
(b) Address Redwood, Md.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof April 15 1947 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location North Ave.

18 (a) Funeral director C. Kenneth Donovan
(b) Address 3615-17 Greenmount Ave.

19 (a) APR 16 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

correct age is especially important. Physicians, please

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15th 1947, at 10 55 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy + Inq thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to
Self Inflicting Gas

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4/15/47 at ? A.M.
(b) Where did injury occur? Roland Park Apts.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Kitchen range 4 Burners + oven on but unlit

23. Signature Earl L. Royer M.D. Medical Examiner.
Date signed 4-15-47

50764

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c ✓

G50764 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Please correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + Saratoga St.
(c) Hospital or institution:
Mercy Hospital Y
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. 15
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6226 Beaufort Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles H Fowble

3 (b) If veteran, name war ?

3 (c) Social Security Account No. 213-10-0642

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Divorced

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26, 1892

8. AGE: Years 54 | Months 10 8 | Days 19 | If less than one day hr. min.

9. Birthplace Carroll County, Md.
(Town, county, and state)

10. Usual Occupation Street Car Operator

11. Industry or business

FATHER
12. Name Thomas Fowble
13. Birthplace Md.

MOTHER
14. Maiden Name Carrie Stiger
15. Birthplace ~~Md.~~ Germany

16 (a) Informant Mrs. Myrtle N. Frantz.
(b) Address Glyndon, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 18/47 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Carroll Co. Md.

18 (a) Funeral director Townsend & Donovan
(b) Address 3645-47 Chestnut Ave

APR 16 1947 (Date received by registrar) (b) Huntington Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1947, at 6 21 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-14 1947 to 4-14 1947 and that I last saw h/her alive on 4-9 1947.

Immediate cause of death	Duration
Cardiac Failure	5 min
Due to Cardiac Decompensation	2 wks.
Due to Coronary Thrombosis	2 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William D. Gentry Jr. M.D.
Address Mercy Hosp Date signed 4-14-47

VS 150

0765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 121

Registered No. G50765

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Please write age in years, months, days, hours, or minutes, as the case may be. Do not use abbreviations or leave blanks. Be sure to answer every question. Please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Timonium Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Timonium Md.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna A. Wagoner

3 (b) If veteran, name war –

3 (c) Social Security Account No. –

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Alexander F. Wagoner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 6, 1870

8. AGE: Years 76 | Months 5 | Days 29 | If less than one day hr. 9 min.

9. Birthplace Pennsylvania (Latta Grove)
(Town, county, and state)

10. Usual Occupation Elder

11. Industry or business

FATHER
12. Name Dave Walker
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Leah Dell
15. Birthplace Pennsylvania

16 (a) Informant Blanche Bowen
(b) Address Timonium Md.

17 (a) Burial (b) Date thereof 4/18/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Mem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 APR 16 1947 (b) Huntington Williams M.D.
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-15 1947, at 555 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-12 1947 to 4-15 1947, and that I last saw h.e.r alive on 4-15 1947.

	Duration
Immediate cause of death Resp. failure	
due to Hypostatic Pneumonia Aut. Sel.	
Due to CVD + cerebral	
angioma due to Fracture	
Due to Hand + Rapid while under	
anesthesia Probable Post Fib. Hem.	
Other Conditions Acute Gangrenous	
Appendicitis	

(Include pregnancy within 3 months of death)

Date of operation 4-12-47

Major findings of operation: Acute Gangrenous Appendicitis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. T. Riggs M. D.

Address Timonium Md. Date signed 4-15-47

0766

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1243

G50766 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Cager & Dukeland.
(c) Hospital or institution: West Baltimore Gen Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1631 N. Monroe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William R. Lusk.

3 (b) If veteran, name war: None

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Gertrude M. Lusk

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1866

8. AGE: Years 80 | Months 9 | Days 29 | If less than one day hr. min.

9. Birthplace Hagerstown, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Long
15. Birthplace Md.

16 (a) Informant Mrs. Anna A. Warner
(b) Address 1631 N. Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/17/47 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 APR 16 1947 (Registered by Registrar) (b) Huntington Williams, M.D. Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Be sure that the information given in items 20 to 23 is correct and complete. Answers to questions in items 21, 22, and 23 are especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 April 1947 at 7:22 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/3/1947 to 4/14 1947 and that I last saw h. alive on 4/14 1947

Immediate cause of death: Cor Lig Lobar Pneumonia — Duration

Due to Cerebral Vas. Dis. Et Thrombosis (?) —

Due to Arteriosclerotic C.V. Dis. Benign Hypertension —

Other Conditions Congestion of Liver & Bilat. Hydrothorax —
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leo Lee G. Hall M.D.
Address 1 West Read Ave. Date signed 4/15/47

VS 150

767

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52a

Registered No. G50767

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1346 Pentwood Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1346 Pentwood Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK JEROME GOMES

3 (b) If veteran, name war: -

3 (c) Social Security Account No. -

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Gladys R. Gomes

6 (c) If alive, give age: 1892 years

7. Birth date of deceased (mo., day, yr.) Dec. 11, (1893)

8. AGE: Years (55) 54 | Months 4 | Days 3 | If less than one day: hr. min.

9. Birthplace (Cal.) Plymouth, Mass
(Town, county, and state)

10. Usual Occupation: Contractor

11. Industry or business: Self

FATHER 12. Name: George Gomes
13. Birthplace: Mass.

MOTHER 14. Maiden Name: Mary
15. Birthplace: Mass.

16 (a) Informant: Mrs. Virginia Tilghman
(b) Address: 1346 Pentwood Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/17/47 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

APR 16 1947 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14, 1947, at 8:00PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 10 1947 to Apr 14 1947 and that I last saw h[illegible] alive on Apr 14 1947.

Immediate cause of death: Laceration of right Kidney - Hadden

Due to:

Due to:

Other Conditions: Nephritis and coronary occlusion
(Include pregnancy within 3 months of death)

Date of operation: March 1 - 1947

Major findings of operation: Cancer of Right Kidney

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Frank Hadden M. D.
Address: 2306 EUTAW PLACE BALTIMORE 17, MD. Date signed 4-15-47

VS 150

PLEASE WRITE PLAINLY. Physicians: please write the cause of death clearly and legibly. Information given is especially important.

0768

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Reg. G50768

PLEASE WRITE PLAINLY with pencil or pen and ink. Physicians: please write the causes of other serious and fatal diseases, if any, which may have caused or contributed to death, but which were not the immediate cause. Please correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6221 Ridgeview Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6221 Ridgeview Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Virgil A Brown

3 (b) If veteran, name war No

3 (c) Social Security Account No. 717-07-9448

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Flora S.

6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) April 15 1909

8. AGE: Years 40 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace West Va (Town, county, and state)

10. Usual Occupation Penns R R Co

11. Industry or business

FATHER 12. Name Thomas Brown

13. Birthplace West Va

MOTHER 14. Maiden Name Bertha Highenbottom

15. Birthplace West Va

16 (a) Informant Flora S Brown

(b) Address 6221 Ridgeview Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 18 47 (month) (day) (year)

(c) Cemetery or crematory Fairmont Cem

Location West Chester Pa

18 (a) Funeral director Nat. H. E. Dugdale

(b) Address 710 Bolton St

19 APR 16 1947 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1947 at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946 to April 15 1947 and that I last saw h alive on April 15 1947

Immediate cause of death Pneumonia

Due to Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Carl Golden M. D.
Address 402 Fairfax Bldg Date signed 4/17/47

VS 150

X

0769

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

G50769
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use no abbreviations. Give full name of deceased. If not in hospital or institution, give residence. If death occurred in hospital or institution, give name instead of street and number. If residence is unknown, give length of residence in city or town where death occurred. If deceased was a child, give name of father or mother. Write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Physicians: please

0770

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G50770

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Use only standard abbreviations. If date of birth is unknown, correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: Church Home + Hospital. 625
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 201 N Broadway (If rural give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country —

3 (a) FULL NAME Mr David Shor.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mrs. Shor.

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Jan 15, 1883

8. AGE: Years 64 | Months 3 | Days 1 | If less than one day ..... hr. ..... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Shoe Repairer

11. Industry or business Grocery

FATHER
12. Name Lyman Shor.
13. Birthplace Russia

MOTHER
14. Maiden Name Rose Blafield.
15. Birthplace Russia

16 (a) Informant Mrs. Lyman Shor.
(b) Address 3906 Baron Ave Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-16-47 (month) (day) (year)

(c) Cemetery or crematory Hebrew Mt. Carmel
Location Fact Newington Ave

18 (a) Funeral director Fact Newington Ave
(b) Address 1429 E Balto St

19 (a) APR 16 1947 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1947, at 1:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 16 1947 to April 16 1947, and that I last saw him alive on April 14 1947.

Immediate cause of death	Duration
Separation of the myocardium	30 min.
Due to arteriosclerotic coronary Thrombosis	30 min.
Due to arteriosclerotic heart disease.	10 yrs.
Other Conditions.	

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature David Bernard M. D.
Address Church Home + Hospital Date signed 4/16/47

Geo B. Merrill MD X

0771

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G50771
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 620 W. Lafayette Ave
(c) Hospital or institution: Dom.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14d
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 620 W. Lafayette Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel (Sam) Harris

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-03-0066

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-10-90

8. AGE: Years	Months	Days	If less than one day
57	3	3	hr. min.

9. Birthplace Oxford, N. C.
(Town, county, and state)

10. Usual Occupation Laborer
11. Industry or business F. S. Royster Guano Co.

FATHER
12. Name Samuel Harris
13. Birthplace N.C.

MOTHER
14. Maiden Name Mary Jones
15. Birthplace N. C.

16 (a) Informant Annabell D. Morgan
(b) Address 1511 W. Lafayette Ave.

17 (a) Burial (b) Date thereof 4/17/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto, Md.

18 (a) Funeral director Charles L. Law
(b) Address 801 Madison Ave.

19 (Date received by local registrar) APR 16 1947 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/13 1947, at 10 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Zubrick M.D.
Medical Examiner.
Date signed 4/14/47

correct age is especially important. Physicians: please write plainly.

VS 151

50772

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Reg. No. 50772

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4684 Falls Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4684 Falls Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William J. Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-01-6930

4. Sex: male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Nettie V.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1879

8. AGE: Years 67 68 | Months 7 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Nettie Virginia Johnson
(b) Address 4684 Falls Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-16-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. Lew. H. Hyland
(b) Address 631 Druid Hill Ave

19 (a) Date received by local registrar APR 16 1947 (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-13-47 9:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1 47, to 4/13 47, and that I last saw h[illegible] alive on 4/13/1947.

Immediate cause of death: Bronchopneumonia — Duration 14 da

Due to: Colds

Due to: Exposure

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy:

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jas. R. Blake M. D.

Address 1327 N. Eutaw Signed

X 4/16/47

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE CLEARLY and fill in the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G50773

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93c

Registered No. G50773

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Give correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1805 Fleet. St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1805 Fleet St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Bledz.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1891

8. AGE: Years 56 | Months 1 | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Pasalski

FATHER 13. Birthplace Poland

MOTHER 14. Maiden Name —

MOTHER 15. Birthplace Poland.

16 (a) Informant Florence Skierski

(b) Address 1805 Fleet St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/17/47 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary

Location Balto. Co.

18 (a) Funeral director Wm. S. Fialkowski

(b) Address 2007 Eastern Ave

19 APR 16 1947 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1947, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/6 1945 to April 13 1947 and that I last saw h[illegible] alive on April 13 1947

	Duration
Immediate cause of death: CEREBRAL HEMORRHAGE	4/2/47
Due to: HYPERTENSIVE CARDIO-VASCULAR DISEASE	4/6/45
Due to	
Other Conditions ARTHRITIS	???

(Include pregnancy within 3 months of death)
Date of operation No OP
Major findings of operations: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jeff E Ogega

Address 209 Balto Date signed 4/14/47

VS 150

50774

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G50774

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: DOA
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 3909 Falls Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Kerr

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife NELLIE KERR
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/7/1900

8. AGE: Years	Months	Days	If less than one day
46	7	8	hr. min.

9. Birthplace N. CAROLINA. (Town, county, and state)
10. Usual Occupation ASSEMBLER
11. Industry or business ?

FATHER
12. Name JAMES KERR
13. Birthplace N. CAROLINA.

MOTHER
14. Maiden Name MARY A. KETCHIE
15. Birthplace N. CAROLINA

16 (a) Informant JACK KERR
(b) Address 2109 M ST. N.E. WASHINGTON D.C

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 4/17/47 (month) (day) (year)
(c) Cemetery or crematory ARLINGTON
Location VIRGINIA.

18 (a) Funeral director W. W. CHAMBERS
(b) Address WASHINGTON D.C.

APR 16 1947 (Date) (Signature) Huntington Williams, MD

correct age is especially important. Physician, please write plainly.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/15 1947, at 7:25 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary artery disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner.
Date signed 4/16/47

50775

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓94a

Reg. 650775

PLEASE WRITE PLAINLY, with ink. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2130 E North Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2130 E. North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George P. Lyons

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. 216-09-0080

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna M. Lyons

6 (c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.) Dec. 12 - 1885

8. AGE: Years: 62 | Months: 2 | Days: 2 | If less than one day: ....hr. ....min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Printer

11. Industry or business Waverly Press

FATHER — 12. Name John H. Lyons

13. Birthplace Balto. Md.

MOTHER — 14. Maiden Name Margaret Heidelmeier

15. Birthplace Balto. Md.

16 (a) Informant Anna M. Lyons

(b) Address 2130 E North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/18/47 (month) (day) (year)

(c) Cemetery or crematory Balto. Cem.

Location North Ave

18 (a) Funeral director Chas. J. Miller Sons

(b) Address 2435 E Oliver St

19 (a) Filed APR 16 1947 (b) Registered by (Signature) Hamilton Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April - 14 - 1947, at 5 30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/2 1947 to 4/14 1947 and that I last saw him alive on 4/13 1947.

Immediate cause of death	Duration
Coronary occlusion	
Due to Arteriosclerosis	
Due to	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Conrad L. Richter M.D.

Address 1706 N. Wash. St. Date signed 4/15/47

X

50776

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 148a

Registered No. G50776

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1106 W. Lexington St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1106 W. Lexington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Walker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: C

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Aaron Walker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 12, 1904.

8. AGE: Years 42 | Months 6 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joseph Butler
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Alice ?
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Aaron Walker
(b) Address 1106 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-16-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Willis
(b) Address 322 N. Schroeder St.

APR 16 1947 (Date received by registrar) Huntington Williams M.D.

correct age is especially important. Typewriter preferred.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1947, at M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Carcinoma of Cervix with Abdominal metastasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kramer, Jr. M.D.
Medical Examiner.
Date signed 15 April 47

X

0777

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55a

Registered No. G50777.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Be sure that the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3506 Woodbrook Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3506 Woodbrook Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Bowers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sophie Nee Sachs

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 14 1895

8. AGE: Years 52 | Months 2 | Days 1 | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business Merchant

FATHER
12. Name Aaron Bowers
13. Birthplace Russia

MOTHER
14. Maiden Name Rebecca Mazer
15. Birthplace Russia

16 (a) Informant Howard G Bowers
(b) Address 3506 Woodbrook Ave

17 (a) Burial (b) Date thereof April 17, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Washington Rd Cem
Location Washington Blvd

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 APR 16 1947 (b) Huntington Williams M.D.
(Date filed by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION 9.45

20. DATE OF DEATH April 15 1947, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 6 1946 to 19, and that I last saw h[illegible] alive on April 14 1947.

Immediate cause of death: carcinoma of the adrenal — Duration

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 17 W Eutaw Pl Date signed 4/16/47

X

BALTIMORE CITY HEALTH DEPARTMENT

0778 BCH B75912 CERTIFICATE OF DEATH 159 Registered C50778

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Corner Redwood & Greene St.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1d
(e) Length of stay in Baltimore (yrs., mos., or days) 1d

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1702 Presstman St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country None

3 (a) **FULL NAME** Baby Dianne Lofton

3 (b) If veteran, name war: None

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4 | 13 | 47

8. AGE: Years 0 | Months 0 | Days 1/2 | If less than one day — hr. — min.

9. Birthplace md (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER 12. Name Father Lofton

13. Birthplace N.C.

MOTHER 14. Maiden Name Zelma Morgan

15. Birthplace N.C.

16 (a) Informant Father Lofton

(b) Address 1702 Presstman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/16/47 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Md

18 (a) Funeral director Geo. D. Kelson

(b) Address 1303 Presstman St

(Signature of registrar) Washington Williams, M.D.

APR 16 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1947, at 2:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 14, 1947, to April 14 1947, and that I last saw he alive on April 14, 1947.

Immediate cause of death	Prematurity	Duration
Due to		
Due to		
Other Conditions		

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]

Address Municipal Hospital Date signed M. D. 4/16/47

X

Write the causes of death clearly and legibly. Physicians: please write those correct age is especially important.

G50779

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 309

G50779 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2346 Eutaw Place.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2346 Eutaw Place. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME SIDNEY STAR WEIL.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 19, 1878.

8. AGE: Years	Months	Days	If less than one day
68	7	27	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Real Estate.
11. Industry or business

FATHER
12. Name M. Star Weil,
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Clara Stern,
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Irene W. Engel,
(b) Address 2346 Eutaw Place.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 4/17/47. (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto. Md.

18 (a) Funeral director Harold Sommerman & Son
(b) Address 1902 Eutaw Place.

19 (a) 1947 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 15th. 1947, at 4 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/30/1947 to 4/15/1947 and that I last saw h[im] alive on 4/15/1947.

Immediate cause of death: Myocardial Infarction — Duration 6 Months
Due to Hypertension & Arteriosclerosis 6 months
Due to
Other Conditions Tertiary Lues 7 years.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature H. Irving Brunkett
Address Emersonian Apts. Date signed 4/15/47

PLEASE WRITE PLAINLY. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

VS 150

G50780

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G50780 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 848 Hollins Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 848 Hollins Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET A. DAVIS

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife Late William B.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22 1871

8. AGE: Years 75 | Months 8 | Days 24 | If less than one day hr. min.

9. Birthplace Cessna
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business at Home

FATHER 12. Name John Connelly.

13. Birthplace Ireland

MOTHER 14. Maiden Name Margaret Henry

15. Birthplace Ireland

16 (a) Informant Mrs Robert L Wolf

(b) Address 5512 Belair Ave Hamilton

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/18/47 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cemetery

Location 4300 Gen Rd Loudon Park

18 (a) Funeral director John Lowndes Son

(b) Address 1202 Hollins St

APR 16 1947 (Date received by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/16/47 19 , at 1:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D.
Medical Examiner.
Date signed 4/16/47

X

G50781

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G50781
Registered No.

PLEASE WRITE PLAINLY, with unfading ink. Physicians: please write the causes of death clearly and legibly. Give correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 825 S. Paca St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 825 S Paca St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANNA. RUKOS
3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex: Female
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: August
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): 1876
8. AGE: Years: 71 Months: Days: If less than one day hr. min.
9. Birthplace: Leith (Town, county, and state)
10. Usual Occupation: Housework
11. Industry or business

FATHER
12. Name ?
13. Birthplace Leith

MOTHER
14. Maiden Name ?
15. Birthplace Leith

16 (a) Informant: Barney Rukos
(b) Address: 825 S Paca St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apl 19-47 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Balto Md
18 (a) Funeral director: Joseph Lanzalotta Jr.
(b) Address: 6 [illegible] Washington Blvd Williamstown Md

APR 16 1947 (Registrar) (b) [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1947, at 9:20 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1947 to April 15 1947, and that I last saw h[illegible] alive on April 13 1947

	Duration
Immediate cause of death: Myocardiotis, Chronic	6 months
Due to: Hypertensive Cardio Vascular Disease	10 years
Due to:	
Other Conditions: Bilateral Cataract (Include pregnancy within 3 months of death)	5 yrs.

Date of operation:
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
(f) Signature: John C. Uhler Jr. M.D.
Address 122 W Washington Blvd Date signed April 16/47

X

G50782

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1220

G50782 Registered No.

Please write the causes of death clearly and legibly. Physicians: please note that correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hosp. 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1020 Wilmer Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert Matthews

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-12-1900

8. AGE: Years 47 | Months 2 | Days 2 | If less than one day hr. min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER: 12. Name ? 13. Birthplace ?

MOTHER: 14. Maiden Name ? 15. Birthplace ?

16 (a) Informant Lillian Brown
(b) Address 1424 Division St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 (month) 17 (day) 47 (year)

(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director William A. Jackson
(b) Address 916 Pennsylvania ave

19 (a) (Date rec'd by registrar) (b) Burlington for Williamsport

1947 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/14/1947 at 4.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/13/1947 to 4/14/1947 and that I last saw h. alive on 4/14/1947.

Immediate cause of death	Duration
Cardiac Resp. Failure	
Due to Intestinal Obstruction	
Due to Volvulus ? sigmoid	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 4/14/47
Major findings of operation: Intestinal distention, volvulus ? sigmoid
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Univ. Hosp. Date signed 4/14

X

G50783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G50783 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1227 (~~1224~~) S. Clinton St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME CHARLES SCHEPLENG

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-5-1886

8. AGE: Years	Months	Days	If less than one day
61	2	11	hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Joseph (Jacob) Schepleng
13. Birthplace Balto Md

MOTHER
14. Maiden Name Wooley ?
15. Birthplace Baltimore

16 (a) Informant Mary E. Bradley
(b) Address 1227 E. Biddle

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-16-1947 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave.

18 (a) Funeral director Lacey & Zeigler Inc.
(b) Address 403 S. Dallas St.

19 (a) (Signature of registrar) Huntington Williams M.D.

APR 16 1947

VS-1M

correct age is especially important, and

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14, 1947, at 6.30 PM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Morrill M.D. Medical Examiner.

Date signed 4-15-47

X

G50784

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G50784

832a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 204 Douglas Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 204 Douglas Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rachael Caldwell

3 (b) If veteran, name war: F
3 (c) Social Security Account No.: ✓

4. Sex: F | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Connely
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb 10/1904

8. AGE: Years	Months	Days	If less than one day
43	2	4	hr. min.

9. Birthplace: S. C. (Town, county, and state)
10. Usual Occupation: H.
11. Industry or business:

FATHER
12. Name: Samuel Lewis
13. Birthplace: S.C.

MOTHER
14. Maiden Name: Sarah Thomas
15. Birthplace: S. Ca.

16 (a) Informant: Gertrude Felder
(b) Address: 204 Douglas Court

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4/17/47 (month) (day) (year)
(c) Cemetery or crematory: Sumter South Carolina
Location:

18 (a) Funeral director: Isaiah L Brown Son
(b) Address: 1096 Montgomery St

19 (a) APR 16 1947 (Date received by registrar) (b) [illegible] (Registrar)

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 14 1947, at 7:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/6/1947 to 4/14/1947 and that I last saw h[illegible] alive on 4/14/1947.

Immediate cause of death: Cerebral Hemorrhage — Duration: 7 days
Due to: Hypertension
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: W. A. Day M.D.
Address: 1222 Harlem Ave Date signed 4/15/47

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians:

G50785

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G50785 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 105 S. Highland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 105 S. Highland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Lenauford Lalay.

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-05-1137

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Laura
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15th 1887

8. AGE: Years	Months	Days	If less than one day
60	2	29	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Carpenter
11. Industry or business Mutual Chemical Co

FATHER
12. Name George Lalay
13. Birthplace Md

MOTHER
14. Maiden Name Grace Young
15. Birthplace Md

16 (a) Informant Mrs. Laura Lalay
(b) Address 105 S. Highland Ave

17 (a) Burial (b) Date thereof 4-17th 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Pine Grove
Location Mt Airy Md.

18 (a) Funeral director Leo F. Leo Cook
(b) Address 1101-03 N. Patterson Park Ave

19 (a) (b)
(Signature of registrar) Registrar

APR 16 1947
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1947, at 1930 M

21. I certify that death occurred on the date above stated; that I attended deceased from 25 Jan. 1947 to 14 April 1947, and that I last saw h[illegible] alive on 14 April 1947

Immediate cause of death	Duration
CORONARY OCCLUSION	2 Hrs
Due to GENERALIZED ARTHRITIS	
Due to	
Other Conditions CERTAIN THROMBOSIS	2½ Yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Wyhrattes M. D.
Address 111 S. HIGHLAND AVE. Date signed 14 APRIL 47

Correct age is especially important. Physicians: please write the

G50786

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G50786 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1735 N. Patterson Park Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) ✓ City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1735 N Patterson Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George B. Haley.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 15th 1878

8. AGE: Years	Months	Days	If less than one day
68	7	29	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name John Haley
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Hemingway
15. Birthplace Md

16 (a) Informant Mrs Garnett Haley
(b) Address 1735 N. Patterson Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-17th 1947 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave Road

18 (a) Funeral director Leo S. Leach
(b) Address 701-03 N. Patterson Park Ave

19 APR 16 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-14th 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1937 to 4-14 1947 and that I last saw h[im] alive on 4-13 1947.

Immediate cause of death	Duration
Atherosclerosis and Cardiac dilatation	3 days
Due to Carcinomatosis	
Due to Carcinoma of parotid gland (Rt.)	10 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. H. Kaywood M.D.
Address 115 E Eager St Balto Date signed 4/16 1947

VS 150

Physicians: please write plainly. Be sure age is especially important.

G50787

BC# 976033

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 87E

G50787

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore General Hospital 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 14 N. Montford Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Nasuro

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/14/47

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Matthew Nasuro
13. Birthplace Baltimore

MOTHER
14. Maiden Name Genevieve Fitzpatrick
15. Birthplace Baltimore

16 (a) Informant Mother
(b) Address 14 N. Montford Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Maryland Memorial
Location Maryland.

18 (a) Funeral director Philip Harvey Son
(b) Address 3024 Auburn St.

Date 4-16-1947 Registrar Arlington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16, 1947 19 at 4:10 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/14/47 19 to 4/16/47 19, and that I last saw her alive on 4/16/47 19

Immediate cause of death	Duration
Respiratory failure	
Cerebral hypoxia	
Due to Not breathing	
Child required resuscitation	
Due to 90 minutes	
immediately following birth.	
Other Conditions Hyaline membrane in	
(Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Cohen M. D.
Address Date signed

PLEASE WRITE PLAINLY, with pen and ink. Use no abbreviations. Do not write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

VS 150

G50788

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G50788 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1305 Gough St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony Mattoni

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary J. Mattoni

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4 1889

8. AGE: Years 57 | Months 11 | Days 9 | If less than one day ... hr. ... min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Foreman

11. Industry or business Sparrows Point

FATHER
12. Name Lorenzo Mattoni
13. Birthplace Italy

MOTHER
14. Maiden Name Maria De Barria
15. Birthplace Italy

16 (a) Informant Mary Mattoni
(b) Address 1305 Gough St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 17, 1947 (Month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road.

18 (a) Funeral director Heydel & Dysard
(b) Address 813 S. Highland Ave

19 (a) APR 16 1947 (Date rec'd by Registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1947, at 6 00 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 4/14/47

correct age is especially important if child is under one year

VS 151

G50789

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 168

G50789 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Edgemere (If outside city or town limits, write RURAL and give town)
(d) Street No. 101 Norris Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Willie Weaver

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1926

8. AGE: Years 21 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace McBean, Georgia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Allen Weaver
13. Birthplace Ga.

MOTHER
14. Maiden Name Minnie Youngblood
15. Birthplace Ga.

16 (a) Informant Minnie Weaver
(b) Address 101 Norris Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/19/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Elroy C Wilson
18 (a) Funeral director
(b) Address 6000 Brantly Ave

19 (a) Apr 19 1947 (Date received by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15, 1947, at 1:50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy/Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH acute peritonitis

Due to Perforated ileum

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury April 12, 1947 9:30 P.M.
(b) Where did injury occur? 101 Norris Lane Edgemere
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Kicked in abdomen by horse

23. Signature Earl L Kay M.D. (Medical Examiner)
Date signed 4-15-47

G50790

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 937

G50790 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St. city
(c) Hospital or institution:
Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Anthony Hundt

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: ?

6 (b) Name of husband or wife: Emma ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/1869

8. AGE: Years 78 | Months 3 | Days | If less than one day hr. min.

9. Birthplace Baltimore, Md USA (Town, county, and state)

10. Usual Occupation Rail Road —

11. Industry or business

FATHER 12. Name Herman B. Hundt

13. Birthplace Germany

MOTHER 14. Maiden Name Elizabeth Ballenau

15. Birthplace Germany

16 (a) Informant Little Sisters of the Poor

(b) Address 1200 Valley St. city

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 18, 1947 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Baltimore

18 (a) Funeral director Lyda Wendefeld

(b) Address 900 East Biddle St.

APR 16 1947 (Date received) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April - 16 1947, at 11:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1947, to April 16 - 1947, and that I last saw him alive on April 16 1947.

Immediate cause of death	Duration
Edema Lungs	2 days
Due to Chronic Myocarditis	6 yr.
Due to	
Other Conditions Arterio Sclerosis	8 yr.

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E Gill Hall

Address 1631 E. North Ave Date signed 4/16/47 M. D.

correct age is especially important

VS 3

G50791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G50791

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calhoun & Fayette
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Finksburg
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME John H Hoffman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary E. Hoffman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 24, 1873

8. AGE: Years	Months	Days	If less than one day
73	11	8 22	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John George Hoffman
13. Birthplace Md.

MOTHER
14. Maiden Name Rosiah Utz
15. Birthplace Md.

16 (a) Informant Mary E. Hoffman
(b) Address Finksburg, Md.

17 (a) Burial (b) Date thereof 4/19/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Trinity Lutheran Cem.
Location Eastview, Carroll Co. - Md.

18 (a) Funeral director Walter & Sons
(b) Address Westminster, Md.

APR 17 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 16 1947, at 7:50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 11 1947 to Apr. 16 1947, and that I last saw him alive on Apr. 11 1947

	Duration
Immediate cause of death: Cardiac decompensation	3½ mos.
Due to: Arteriosclerotic heart disease	?
Due to: Generalized arteriosclerosis	?
Other Conditions: Prostatic hypertrophy	6 mos.?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stanley B. Klyanowicz M.D.
Address Franklin Square Hosp. Date signed 4-17-47

VS 150

PLEASE WRITE PLAINLY; write the cause of death clearly and legibly. Physicians: please write the correct age is especially important.

50792

AB-109815

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30 C

Registered No. G50792

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5days
(e) Length of stay in Baltimore (yrs., mos., or days) 24yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2406 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles William Jones

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-12-8039

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Bella May Stewart

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14- 1875

8. AGE: Years 71 | Months 9 10 | Days 2 | If less than one day hr. min.

9. Birthplace Pa. (Lock Ha[illegible] Co.)
(Town, county, and state)

10. Usual Occupation Merchant Clerk

11. Industry or business Balto. National Bank

FATHER
12. Name Charles William Jones, Sr.
13. Birthplace Pa.

MOTHER
14. Maiden Name Lydia DeLong
15. Birthplace Pa.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 4/18/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Maryland Park
Location Parkville, Md.

18 (a) Funeral director Williams Cook Inc.
(b) Address 217 St. Paul St.

19 (a) APR 17 1947 (b) Huntington Williams, Mgr.
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 19 47 at 5.25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-11- 19 47 to 4-16 19 47 and that I last saw h[illegible] alive on 4-16 19 47

Immediate cause of death Confluent bronchopneumonia — Duration 2 days

Due to Hypertensive cardio-vascular disease

Due to Hemiplegia extremities Comminuted wounding and

Other Conditions multiple punctures and cuts.
History of mononephilia.
(Include pregnancy within 3 months of death)

Date of operation 4/14/47

Major findings of operation Carotid supply of brain.

of autopsy by above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. L. Gibbs
Address Baltimore City Hosp. Date signed 4/16/47

PLEASE WRITE PLAINLY with pen or pencil. Physicians: please write the causes of death clearly and accurately. Correct age is especially important.

VS 150

G50793

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1 61

Registered No. G50793

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Sinai Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Balto. 8
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1237 Darley Ave
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Anna K. Middleton.

3 (b) If veteran, name war: W

3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of husband ~~or wife~~: Clarence Middleton

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 23rd 1883

8. AGE: Years: 64 | Months: 2 | Days: 23 | If less than one day: .....hr. .....min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business: At Home

FATHER
12. Name: John W. Emerine
13. Birthplace: Balto. Co. Md.

MOTHER
14. Maiden Name: Margaret Schneider
15. Birthplace: Balto. Md.

16 (a) Informant: Clarence Middleton
(b) Address: 1237 Darley Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 4/19/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~: Loudon Park
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 E. Pennsylvania Ave.

APR 17 1947 (Date received by Registrar) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/16 1947, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/10 1947, to 4/16 1947, and that I last saw her alive on 4/16 1947.

Immediate cause of death: Myocardial Infarction, Pneumonia

Due to: Diabetes Mellitus

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature [signature]
Address 5 West Hoyt. Date signed 4/16 M.D.

X

PLEASE WRITE VERY CLEARLY. Physicians: please write correct age is especially important.

50794

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered 50794

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State ~~Maryland~~ Ohio (b) County Hamilton
(c) City or town ~~Baltimore~~ Shadeland Park Newtown
(If outside city or town limits, write RURAL and give town)
(d) Street No. ~~2527 Guilford Ave.~~
(If rural give location)
(e) Citizen of foreign country? ~~No~~ (Yes or No)
If yes, name country

3 (a) FULL NAME Prudence Ann Norris

3 (b) If veteran, name war	3 (c) Social Security Account No.
N	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	Single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1946

8. AGE: Years	Months	Days	If less than one day
0	9	11	hr. min.

9. Birthplace Ohio (Town, county, and state)
10. Usual Occupation none
11. Industry or business none

FATHER
12. Name John C. Norris
13. Birthplace Missouri

MOTHER
14. Maiden Name Claudine Dunivant
15. Birthplace Missouri

16 (a) Informant Hospital Records
(b) Address Union Memorial Hosp.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/17/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) APR 17 1947 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1947, at 9:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 31 1947 to April 15 1947, and that I last saw her alive on April 15 1947.

Immediate cause of death: Typhoid Fever — Duration: 16 days (at least)
Due to
Due to
Other Conditions: Cardiac Decompensation — 1 day.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ernest V. deMoss M. D.
Address Union Mem. Hosp. Date signed 4-15-47

PLEASE WRITE correct age is especially important. Physicians: please write

VS 150

50795

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G50795

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd Calvert ST.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore.
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2621 Barclay ST, Balt. 18 (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No) If yes, name country Ireland.

3 (a) FULL NAME Mrs. George Robert McKenna. (Katherine)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fem.	White	married.

6 (b) Name of husband or wife George A. McKenna
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 13th 1900

8. AGE: Years	Months	Days	If less than one day
46	8	3	hr. min.

9. Birthplace Ireland. (Town, county, and state)
10. Usual Occupation housewife.
11. Industry or business

FATHER
12. Name Michael Curran.
13. Birthplace IRELAND

MOTHER
14. Maiden Name Josephine ?
15. Birthplace Ireland.

16 (a) Informant Geo. R. McKenna
(b) Address 2621 Barclay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/18/47 (month) (day) (year)
(c) Cemetery or crematory St. Peters
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (Date received by reg.) APR 17 1947 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1947, at 2:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 14 1947, to Apr. 16 1947, and that I last saw h.e.r. alive on Apr. 16 1947.

Immediate cause of death	Duration
Myocardial insufficiency	4 days
Due to Coronary Thrombosis.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address Union Mem. Hosp. Date signed 4-16-47.

VS 150

X

50796

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G50796 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22
(c) Hospital or institution: South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 107 Welcome alley (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Caldwell Whitehurst

3 (b) If veteran, name war

3 (c) Social Security Account No. 231-10-3931

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/15/1905

8. AGE: Years	Months	Days	If less than one day
41 42	3	29	hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER
12. Name George Whitehurst
13. Birthplace N. C.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Fannie Whitehurst
(b) Address 704 East City Hall Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/17/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Ct
Location Isaac L Brown & Son

18 (a) Funeral director 101 W Montgomery St
(b) Address

19 APR 17 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1947 at 10:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl W Ryon M.D. Medical Examiner.
Date signed 4-14-47

correct age is especially important.

VS 191

G50797

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G50797

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 369 Oberly Avenue- Essex
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: CHRISTIAN ZULAUF

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Carmella

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1912

8. AGE: Years 35 | Months | Days | If less than one day hr. min.

9. Birthplace: Balto. County
(Town, county, and state)

10. Usual Occupation: Truck Driver

11. Industry or business: Dairy

FATHER
12. Name: W F Zulauf
13. Birthplace: Md

MOTHER
14. Maiden Name: Emma Meeks
15. Birthplace: Md

16 (a) Informant: Elizabeth Crosse
(b) Address: 412 Beck Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-15-47 (month) (day) (year)
(c) Cemetery or crematory: Oak Grove
Location: Balto Co.

18 (a) Funeral director: H Bruzdzinski
(b) Address: 1407 Eastern Ave Rd

19 (a) APR 17 1947 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

Correct age is especially important

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15, 1947, at 11.15 a.m.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Hemorrhage due to traumatic rupture of Heart.

Due to

Other Conditions: Rupture of liver
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: Balto. Co.
(a) Date of injury 4-15-47 at 10.30 a.m.
(b) Where did injury occur? Eastern Ave. & Langley Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? Yes
(d) Means of injury: truck overturned

23. Signature: Earl L Ryan M.D.
Medical Examiner.
Date signed 4-15-47

50798 CWK-109121

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50798

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 3-
(e) Length of stay in Baltimore (yrs., mos., or days) 12 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Washington
(c) City or town Hagerstown (If outside city or town limits, write RURAL and give town)
(d) Street No. 675 Panna Avenue (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Eloise Adell Shipley

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Osborne W. Shipley
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 12-1916

8. AGE: Years	Months	Days	If less than one day
30	10	4	..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John G. Hoke
13. Birthplace West Virginia

MOTHER
14. Maiden Name Edna B. Iseminger
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/17/47 (month) (day) (year)
(c) Cemetery or crematory Rest Haven
Location Hagerstown Md

18 (a) Funeral director F.K. Coffman
(b) Address Hagerstown Md.

19 (a) APR 17 1947 (Date received by registrar) Huntington Williamsport

MEDICAL CERTIFICATION P

20. DATE OF DEATH April 16 19 47 at 1:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 13 19 47 to Apr. 16 19 47 and that I last saw her alive on Apr. 16 19 47.

Immediate cause of death	Duration
Tuberculosis, Pulmonary	21 Mos. (?)
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Refused

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wilbur J. Hurst M. D.
Address Balt. City Hosp. Date signed 4-17-47

VS 150

Please write the cause of death correctly and fill out all items. Physicians: please write correct age in especially important.

50799

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. C50799

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. Temple Garden Apartments (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

Blanks not filled in because info not obtained by business office

3 (a) **FULL NAME** Sidney Mayer

3 (b) If veteran, name war X | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Wid

6 (b) Name of ~~husband or~~ wife Goldie Fay Mayer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 6, 1878

8. AGE: Years	Months	Days	If less than one day
69	2	10	hr. min.

9. Birthplace Altoona, Pa. (Town, county, and state)
10. Usual Occupation Heating Equipment
11. Industry or business Salesman

FATHER
12. Name Mat Mayer,
13. Birthplace Germany.

MOTHER
14. Maiden Name Henrietta Goldenberg
15. Birthplace Germany.

16 (a) Informant Mrs. Sidney F. Mayer
(b) Address Phila. Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/18/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director Harris Sonnenstein & Sons
(b) Address 1902 Eutaw Place

19 (a) APR 17 1947 Huntington Williams, M.D.
(b) Registered by

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1947, at 9 02 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 15 1947, to April 16 1947, and that I last saw him alive on April 16 1947.

Immediate cause of death	Duration
Cystal agenesis	18 hrs.
Adams-Stokes syndrome	2 yrs
Due to	
Due to Cause not determined	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Cystic sclerotic disease
Autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman R. Trueman Jr. M. D.
Address Union Memorial Hosp. Date signed April 16, '47

95a

PLEASE WRITE THE CAUSES OF DEATH CLEARLY. Write only one cause on a line. Give only one cause unless others are necessary. State the disease causing death, or in deaths from violence, the nature of injury. Do not use such terms as heart failure, exhaustion, asthenia, etc., alone. Indefinite or unsatisfactory causes will be returned for correction. Operations should be reported only when performed for some condition which is a cause of death. Statements of duration of each cause of death are necessary. Deaths from violence must be reported to the Coroner. Physicians: please write correct age is especially important.

G50800

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G50800

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Hospital 5-
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 242 Forrest St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Delia Swift Hill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife Archie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10 - 1894

8. AGE: Years	Months	Days	If less than one day
52	11	5	.....hr. .....min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Warner Swift
13. Birthplace Va

MOTHER
14. Maiden Name Millie McLeod
15. Birthplace Va

16 (a) Informant Archie Hill
(b) Address 242 Forrest St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/18/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County Md

18 (a) Funeral director Joseph G. Lobl Jr.
(b) Address 1304 N Central Ave

19 APR 17 1947 Huntington Williams, M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15, 1947, at 8 40 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy + Insp thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature [signature] M.D. Medical Examiner.
Date signed 4-15-47

Correct age if erroneously stated.

VS 181

G50801

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12B

Registered No. G50801

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 421 Oxford St. (If rural, give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Evelyn Vaughn

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 3-22-17

8. AGE: Years 30 | Months - | Days 25 | If less than one day ..... hr. ..... min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER — 12. Name Nathaniel Vaughn
13. Birthplace Va

MOTHER — 14. Maiden Name Adley Neal
15. Birthplace Va

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-12-47 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Arbutus, Md.

18 (a) Funeral director Charles R. Law
(b) Address 801 Mad. Ave.

19 (a) APR 17 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1947, at 2 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 15 1947 to April 16 1947 and that I last saw him alive on Apr 15 1947.

Immediate cause of death Pulmonary Tuberculosis — Duration 7

Due to Sarcoidosis of lungs liver, lymph nodes

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... (Specify type of place) While at work?.....
(e) Means of injury.....

23. Signature Robert C. Auerbach
Address Johns Hopkins Hosp. Date signed Apr 17 1947 M.D.

PLEASE WRITE PLAINLY. Physicians: please write the cause of death clearly and correct age is especially important.

VS 150

050802

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 050802

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2009 McCulloh Street
(c) Hospital or institution: 14

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Down Green

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Leola Collier Green
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 8, 1916

8. AGE: Years 30 | Months 7 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Motion Picture Operator

11. Industry or business Jean Theatre

FATHER
12. Name Thaddius Green
13. Birthplace Maryland

MOTHER
14. Maiden Name Evelyn Woodland
15. Birthplace Baltimore Md.

16 (a) Informant Leola C. Green
(b) Address 2009 Mc Culloh Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/18/47 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn Cem.
Location Baltimore, Maryland

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Ave.

19 (a) Filed by Apr 17 1947 (b) Registrar [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1947, at 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1947, to April 13 1947, and that I last saw h[illegible] alive on April 1947

	Duration
Immediate cause of death: Acute heart failure - Embolic phenomena	— hr.
Due to: Rheumatic endocarditis	— 1
Due to: Rheumatic fever	1929
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 1422 S. Chase Date signed 4/16/47 M. D.

Head, Refer

PLEASE WRITE PLAINLY; correct are especially important. Physicians: please write the cause of death clearly

G50803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G50803

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 406 N. Dallis Street
(c) Hospital or institution:

6-

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 406 N. Dallis Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry E. Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-10-1760

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Sadie Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 20, 1890

8. AGE: Years	Months	Days	If less than one day
56	3	24	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business

FATHER
12. Name Charles Johnson
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah ?
15. Birthplace Md.

16 (a) Informant Mrs. Sadie Johnson
(b) Address 406 N. Dallis St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-17-47 (month) (day) (year)
(c) Cemetery or crematory BALTIMORE NATIONAL CEM.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 528 W. Biddle St.

APR 17 1947 (Date rec'd by registrar) (b) Funeral Home, Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13, 1947, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-8-47 19 to 4-13-47 19 and that I last saw him alive on 4-12- 1947.

Immediate cause of death
(a) Hemmorrhage

Duration 5 days

Due to

Due to

Other Conditions PROBABLE GASTRIC ULCER
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marvin Adams, M.D.
Address 237 N. Chapel Date signed 4-14-47

PLEASE WRITE PLAINLY, with ... correct age is especially important. Physicians: please write the ... the causes of death clearly and ... agency.

VS 150

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. 050804

0804

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1225 Union Avenue
(c) Hospital or institution:
13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1225 Union Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Agnes Marie Canoles

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: William L. Canoles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29-1896

8. AGE: Years 50 | Months 10 | Days 16 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Maryland (town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name John Thomas Miles
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie Elizabeth Lewis
15. Birthplace Maryland

16 (a) Informant William L. Canoles
(b) Address 1225 Union Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 18-1947 (month) (day) (year)
(c) Cemetery or crematory St. Mary's Famedom
Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3621 Falls Road

19 (a) APR 17 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1947, at 12-30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945 to April 15 1947, and that I last saw h e r alive on April 15 1947.

Immediate cause of death	Duration
Generalized Carcinomatosis	6 mo
Due to Carcinoma of Breast	1 year
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. J. Shimanek M. D.
Address 3711 Falls Rd Date signed 4-16-47

L. J. Shimanek

Please write clearly. Physicians: please write the correct age is especially important.

0805 PENDERGRASS

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1 8 0

B# B-68125

Registered No. G50805

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 D
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1015 Myrtle Ave (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Dorothy Mary Pendergrass

3 (b) If veteran, name war.....
3 (c) Social Security Account No.....

4. Sex F | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Infant.

6 (b) Name of husband or wife.....
6 (c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.) 1-17-47

8. AGE: Years..... Months 2 Days 29 If less than one day .....hr. .....min.

9. Birthplace Baltimore Md (Town, county and state)

10. Usual Occupation Child

11. Industry or business.....

FATHER
12. Name Nathaniel Pendergrass
13. Birthplace S.C.

MOTHER
14. Maiden Name Alice Bennett
15. Birthplace Ga.

16 (a) Informant Nathaniel Pendergrass
(b) Address 1015 Myrtle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 17 47 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director Williams & Jackson
(b) Address 916 Linden ave

19 (a) APR 17 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/16 1947, at 12 50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/15 1947 to 4/16 1947, and that I last saw h[illegible] alive on 4/16 1947.

Immediate cause of death Massive atelectasis (aspiration)

Due to Prod of 2nd degree burns

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy.....

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 4/15 at 11 30 M
(c) Where did injury occur? Home - Balto. Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work?.....
(e) Means of injury Fire

23. Signature Nathaniel Pendergrass M.D.
Address University Hosp. Date signed 4/16/47

PLEASE WRITE PLAINLY. Physicians: please write correct age is especially important.

VS 150
To be approved by Medical Examiner — George L. Merrill MD

50806

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

✓ G50806 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2744 Riggs Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-7
(e) Length of stay in Baltimore (yrs., mos., or days) 46 YEARS

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County —
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2744 Riggs Ave (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country NO

3 (a) FULL NAME VERNON Wille

3 (b) If veteran, name war NONE

3 (c) Social Security Account No. 218-05-4385

4. Sex MALE | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife NONE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JANUARY 7, 1901

8. AGE: Years 46 | Months 3 | Days 8 | If less than one day — hr. — min.

9. Birthplace BALTIMORE, MD (Town, county, and state)

10. Usual Occupation PAINTER (House)

11. Industry or business BUILDING

FATHER 12. Name John W. Wille

13. Birthplace BALTIMORE, MD

MOTHER 14. Maiden Name Lillie FERREC

15. Birthplace BALTIMORE, MD.

16 (a) Informant Miss Ruth H FERREC

(b) Address 2744 Riggs Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/19/47 (month) (day) (year)

(c) Cemetery or crematory Western Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

17 (b) Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1947 at 6:57 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 23 1947, to April 15 1947 and that I last saw him alive on April 14 1947.

Immediate cause of death CANCER OF the Lungs — Duration 6 MONTHS

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at — M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury —

23. Signature Melvin N. Burdett

Address 2030 W. Fayette St Date signed 4/15/47 M. D.

PLEASE WRITE PLAINLY, with pen and ink. Physicians: please write the causes of death clearly and correct age is especially important.

VS 150

50807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 50807

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1912 Barclay St.
(c) Hospital or institution: 12

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) 4
(d) Street No. 1912 Barclay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Sullivan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F Female	White	

6 (b) Name of husband or wife Michael J. Sullivan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 6, 1874

8. AGE: Years	Months	Days	If less than one day
72	6	10	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business at home

FATHER
12. Name Owen Grady
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Stevens
15. Birthplace Ireland

16 (a) Informant Mrs Arthur Keenan
(b) Address 1912 Barclay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-19-1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd.

18 (a) Funeral director Edward P. Cockbill & Son
(b) Address 924 E. Eager St.

19 (a) APR 17 1947 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16, 19 47, at 12 01 M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1946 to April 15 1947. and that I last saw h er alive on April 15 1947.

Immediate cause of death	Duration
Coronary Occlusion	1/2 hour
Due to Coronary Sclerosis	1 Year
Due to Arteriosclerosis	1 Year
Other Conditions Hypertension	1 Year

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J. Mark M.D.
Address 532 E. 22nd St Date signed 4/16/47

PLEASE WRITE LEGIBLY. Use ink. Do not use pencil. Be sure to write the cause of death correctly. Be sure to give the correct age. This is especially important. Physicians: please write legibly.

VS 150

X

G50808

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48B

Registered No. G50808

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4910 Chalgrove Ave.
(c) Hospital or institution:

27-17

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4910 Chalgrove Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maria Grazia Vinci,

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	Widow

6 (b) Name of husband or wife Agostino, Vinci,
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1881

8. AGE: Years	Months	Days	If less than one day
65	10	14 15	hr. min.

9. Birthplace Cefalu, Palermo
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business at home

FATHER
12. Name Frank Currieri,
13. Birthplace Palermo,

MOTHER
14. Maiden Name Concetta D'Alfonza
15. Birthplace Palermo,

16 (a) Informant Mrs. Anna J. Julio,
(b) Address 4912 Chalgrove Ave.,

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 4/19 /47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director C. Vernon Lemmon.
(b) Address 4611 Park Heights Ave.

19 (a) [redacted] (b)

Registrar

S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14, 1947, at 10.30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/25 1946 to 4/14 1947
and that I last saw her alive on 4/13 1947

Immediate cause of death Carcinoma uteri

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. D.
Address 1123 St.Paul St. Date signed

X

G50809

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

Registered No. G50809

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1208- Waldo Court. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dowd Yarborough

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Annie Mae

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17, 1915

8. AGE: Years 32 | Months - | Days 27 | If less than one day ____ hr. ____ min.

9. Birthplace Winston Salem, N. C. (Town, county, and state)

10. Usual Occupation Pipe Fitter

11. Industry or business Md. Drydock Co. Inc.

FATHER 12. Name Julius Yarborough

13. Birthplace N. C.

MOTHER 14. Maiden Name Elmonia Harston

15. Birthplace unknown

16 (a) Informant Annie Mae Yarborough

(b) Address 1208 Waldo Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/17/47 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Elroy D. Wilson

(b) Address 2220 Brantley Ave

19 (a) APR 17 1947 (Date rec'd by registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13th 1947, at 5:03 a. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury found 4/13/47 at 5:03 P. M. 4/11

(b) Where did injury occur? Harbor - Fallsway north of Pratt St.

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? Unknown

(d) Means of injury Drowning - Found

23. Signature Earl L. Royer M.D. (Medical Examiner)

Date signed 4-14-47

correct age is especially important. A mistake in

VS 151

X

C50810

261330

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. C50810

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 122 S. Bond St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sylvester White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	black	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-4-84

8. AGE: Years	Months	Days	If less than one day
62	11	10	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation laborer

11. Industry or business

FATHER
12. Name George White
13. Birthplace Maryland ?

MOTHER
14. Maiden Name Mary Butler
15. Birthplace ?

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 4/19/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Elroy C. Wilson

18 (a) Funeral director
(b) Address 1000 Eutaw Pl. Balto

19 APR 17 1947 (b) Huntington Nelligan, M.D.
(Date received by local registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1947 at 12 50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-31- 1947 to 4-14 1947, and that I last saw him alive on 4-14- 1947.

Immediate cause of death Resp. failure

Due to Cardiac hemorrhage

Due to Gen. arteriosclerosis

Other Conditions Prostatic hyp.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin Dunn M. D.
Address Jhd Date signed 4-15-47

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly. The correct age is especially important.

VS 150

X

G50811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G50811

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 25 S
(c) Hospital or institution: Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Brooklyn (If outside city or town limits, write RURAL and give town)
(d) Street No. 1032 Jack Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Armand S. Gravely

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Bernice V.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 5th 1916

8. AGE: Years	Months	Days	If less than one day
31	2	11	hr. min.

9. Birthplace Wav W. Va. (Town, county, and state)

10. Usual Occupation Engineer

11. Industry or business Merchant Marine

FATHER
12. Name Geo. E. Gravely
13. Birthplace Maryland

MOTHER
14. Maiden Name Revg Hamilton
15. Birthplace Maryland

16 (a) Informant Bernice Gravely
(b) Address 1032 Jack Place

17. Removal (b) Date thereof 4/18/47 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sharmon Church
Location Catonsville Md

18 (a) Funeral director Gilbert Ford Jr
(b) Address

19 (a) APR 17 1947 (Date rec'd by registrar)

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correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1947 at 10:50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Subdural Hemorrhage

Due to Trauma

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-15-47 at ? M.
(b) Where did injury occur? 1032 Jack Place
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Fell striking head on moving machine

23. Signature M.D. Medical Examiner.

Date signed 4-16-47

50812 512949

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

128 Registered No. 50812

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 315 N. Broadway (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Frank Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Hazel

6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) 3-1-06

8. AGE: Years 41 | Months 1 | Days 15 | If less than one day .....hr. .....min.

9. Birthplace Ohio (Town, county, and state)

10. Usual Occupation Burner

11. Industry or business

FATHER 12. Name Joseph Smith
13. Birthplace Ohio

MOTHER 14. Maiden Name Mary Ranker
15. Birthplace Ohio

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 18 47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Welsh Funeral Home
(b) Address 2108 Orleans St

19 Filed APR 17 1947 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH April 16 1947, at 1:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 4 1947, to April 16 1947, and that I last saw him alive on April 16 1947

Immediate cause of death Cholemia with jaundice, severe — Duration 3 M's

Due to Unknown cause.

Due to.....

Other Conditions Acute hemorrhagic pancreatitis, Ascites — Duration 7

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy: As Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature Eugene Leuper II M. D.
Address Johns Hopkins Hosp. Date signed April 16 47

PLEASE WRITE PLAINLY. Please write the cause of death clearly and legibly. Physicians: please write correct age is especially important.

VS 150

125B

G50813 Heim

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G50813

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Hampstead Ave
(c) Hospital or institution: Pine Ridge Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 27-9

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Pentridge Apts (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Edwin Heim

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-03-5952

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Bessie E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16-1878

8. AGE: Years 68 | Months 69 | Days 9/10 | 29 | If less than one day hr. min.

9. Birthplace York - Pa. (Town, county, and state)

10. Usual Occupation Linotype Operator

11. Industry or business

FATHER 12. Name Jacob Heim

FATHER 13. Birthplace Unknown

MOTHER 14. Maiden Name Unknown

MOTHER 15. Birthplace "

16 (a) Informant Charles Edward Heim

(b) Address Pentridge apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 18-47 (month) (day) (year)

(c) Cemetery or crematory Moreland Memorial

Location Balto. Md.

18 (a) Funeral director Sambrook Funeral Home Inc.

(b) Address 44 E. North Ave

19 (a) APR 17 1947 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1947, at 4:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1941, to April 15 1947. and that I last saw h.im alive on April 15 1947.

Immediate cause of death: Coronary Occlusion — Duration last

Due to Arteriosclerosis — Years

Due to heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Lee Hewson M. D.

Address 20 E. Preston Street Date signed 4/17/47

PLEASE WRITE PLAINLY. Physicians: please write correct age is especially important.

VS 8

X

50814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. C50814

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1318 S Carey ST
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 2
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1318 S Carey ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Koellner Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband ~~or wife~~ of Pembroke Harris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 27, 1876

8. AGE: Years 70 | Months 5 | Days 19 20 | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Ferdinand Frank
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs Freida Talley
(b) Address 1222 S Carey ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 19 '47 (month) (day) (year)
(c) Cemetery or crematory Westview
Location Edmondson Ave & Longwood St

18 (a) Funeral director Harry W Weigle
(b) Address 4101 Edmondson Ave

19 (a) APR 17 1947 (b) Registrar's signature Huntington Willis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1947 at 2-20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3 6 1941 to 4-16 1947 and that I last saw him alive on 4 16 1947

Immediate cause of death	Duration
Acute Cardiac Failure	1 da
Due to Chronic Myocarditis	5 yr
Due to Carcinoma of Ascending Colon with metastases	6 mos
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph E Lancaster M. D.
Address 6700 Wayne Ave Date signed 4/17/47

PLEASE WRITE correct age is especially important. Physicians: please write

VS-150

G50815 Mannberg 72a G50815

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, with ... the causes of death clearly and ... are is especially important. Physicians: please write the ...

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Balto. General Hospital 24
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1414 Hull St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward W. Mannberg.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27, 1929

8. AGE: Years	Months	Days	If less than one day
17	10 11	19	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER
12. Name Joseph Mannberg
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Hauser
15. Birthplace Austria

16 (a) Informant Joseph Mannberg
(b) Address 1416 Hull St.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 4/16/47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem.
Location B. A. County

18 (a) Funeral director Charles F. Dill
(b) Address 1501 E. Fort Ave

19 47 (Date rec'd by reg.) Wilmer Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 23 1947, to April 15 1947, and that I last saw h... alive on April 15 1947.

Immediate cause of death	Duration
Acute Cardiac failure	
Due to Acute Glomerulo-Nephritis	
Due to Henoch's Purpura	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Leverett Hall M. D.
Address 1211 Light St Date signed 4-15-47

VS 150

G50816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (93)

G50816 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2714 Kinsey Ave
(c) Hospital or institution: at home 20-
(d) Length of stay in hospital or inst. (yrs., mos., or days) at home
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2714 Kinsey Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET Boland (MARGARET AMELIA BOLAND)

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: John H Boland
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.): About 1877
8. AGE: Years: abt 70 | Months: ? | Days: ? | If less than one day: hr. min.
9. Birthplace: Baltimore Md (Town, county, and state)
10. Usual Occupation: none
11. Industry or business: none

FATHER
12. Name: Leonidas Tyler
13. Birthplace: Eastern Shore Md

MOTHER
14. Maiden Name: Tyresa — ? —
15. Birthplace: Germany —

16 (a) Informant: Margaret A Boland (Granddaughter)
(b) Address: 2714 Kinsey Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 1947 (month) (day) (year)
(c) Cemetery or crematory: Mt Olivet
Location: Baltimore —

18 (a) Funeral director: Jos. Jaerdens Sons
(b) Address: 1927 Park Ave.

19 (a) (Signature of local registrar) (b) Huntington Williams M.D. Registrar

APR 17 1947

VS 151

correct age is especially important

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/16/47 19 , at 4:30 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D.
Medical Examiner.
Date signed 4/16/47

G50817

G50817

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland ✓
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution: The Seton Institute 28-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 47-7-2
(e) Length of stay in Baltimore (yrs., mos., or days) 43yrs.+

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6420 Reisterstown Road (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah B. Schraeder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race white

6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-7-1857

8. AGE: Years 89 | Months 6 | Days 9 | If less than one day hr. min.

9. Birthplace New Mexico (Town, county, and state)

10. Usual Occupation unemployed for years

11. Industry or business

FATHER
12. Name H. B. Schroeder
13. Birthplace Frederick County, Maryland

MOTHER
14. Maiden Name Priscilla McClure
15. Birthplace Harrisburg, Pennsylvania

16 (a) Informant The Seton Institute
(b) Address 6420 Reisterstown Rd., Balto 15, Md.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 4-18-47 (month) (day) (year)

(c) Cemetery or crematory St Mary's
Location Petersville-Frederick Co. Md

18 (a) Funeral director Stuart Moore Co.
(b) Address 108 W North Ave.

19 (a) Date of this report APR 17 1947 (b) Livingston Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-16 1947, at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1930, to 4-16 1947, and that I last saw h alive on 4-16 1947.

Immediate cause of death myocardial infarct — Duration 6 weeks

Due to

Due to general arteriosclerosis

Other Conditions schizophrenia — paranoid type
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 33 W Read St Date signed

PLEASE WRITE PLAINLY, with ink. Spell out full words. Do not use abbreviations. Do not leave any blanks. If the deceased was a child, or a woman who died during pregnancy, state the number of completed years of age. Physicians: please write the causes of death clearly and accurately. Correct age is especially important.

VS 150

0818 BALTIMORE CITY HEALTH DEPARTMENT G50818
CERTIFICATE OF DEATH 108 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 604 S. Bradford St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 604 S Bradford St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Olszewski Olszewski Patro

3 (b) If veteran, name war
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife George

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name George Zawacki
13. Birthplace Poland

MOTHER 14. Maiden Name Ostrowski
15. Birthplace Poland

16 (a) Informant George Olszewski
(b) Address 604 S Bradford St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 19/47 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore

18 (a) Funeral director Fred W. Ozaczewski
(b) Address 1930 Eastern Ave.

(a) APR 18 1947 (Date rec'd by registrar) (b) Washington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1947, at 6 55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 9 1947, to Apr. 15 1947, and that I last saw h alive on Apr. 15 1947.

Immediate cause of death Senility — Duration

Due to Pneumonia (4/6/47) — week

Due to Left lower lobe

Other Conditions Bleeding from — years
int. and external Hemorrhoids
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sigmund R. Novak M. D.
Address 401 S. Patt. Pk. Ave. Date signed 4/16/47

PLEASE WRITE PLAINLY. Use ink. Do not use pencil. Please write the causes of death clearly and correct age is especially important. Physicians: please write the

VS 150

0819

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

R C50819

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2723 Harlem Ave.
(c) Hospital or institution:
16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Maryland (If outside city or town limits, write RURAL and give town)
(d) Street No. 2723 Harlem Ave. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME James Thomas Moorehead

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Emma B. Moorrhead
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Jan. 29, 1871

8. AGE: Years	Months	Days	If less than one day
76	2	18	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Thomas Moorehead
13. Birthplace Scotland

MOTHER
14. Maiden Name Mary Harten
15. Birthplace Scotland

16 (a) Informant Mr. George J. Moorehead
(b) Address 2723 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 19, 47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

APR 18 1947 Huntington Williams M.D.
(b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1947, at 12.45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 1946 to Apr. 16 1947
and that I last saw h[illegible] alive on Apr. 16 1947

Immediate cause of death	Duration
Myocarditis Acute Dilatation of Heart	
Due to General Arterio Sclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: ✓
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? ✓
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ While at work?
(Specify type of place)
(e) Means of injury ✓

23. Signature Edw. A. Tracewell M.D.
Address 121 Dallas Date signed 4/17/47

VS 150

Please write plainly. Physician: please write correct age is especially important.

50820 TH.

BALTIMORE CITY HEALTH DEPARTMENT

106493 CERTIFICATE OF DEATH 1318

G50820 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4- Mo. 17-days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 121 Perry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Butler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Col

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 17th 1921

8. AGE: Years 25 | Months 4 | Days 29 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Morris Butler
13. Birthplace Maryland

MOTHER
14. Maiden Name Anna Anderson
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 20-47 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Balto. Md

18 (a) Funeral director James A Hayes
(b) Address 1142 Eastfield St

APR 18 1947 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16th 1947 at 5.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 29th 1946 to Apr. 16 1947, and that I last saw h her alive on Apr. 16 1947.

Immediate cause of death: Pulmonary oedema — Duration

Due to: Chronic glomerulonephritis

Due to:

Other Conditions: ① Chronic pyelonephritis ② Pancreatic necrosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edwin C. Evans M. D.
Address Balto. City Hosp. Date signed 4-16-47

Please write correct age is especially important. Physicians: please write

VS 150

X

0821

CWK-108559

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

G50821 Registered No.

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and fill in correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 22 2- 1Mx 2 Mos. 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 10 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 138 W. Camden Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Newkirk Howden

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 4-1857

8. AGE: Years	Months	Days	If less than one day
89	8	8	hr. min.

9. Birthplace Illinois (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Andrew
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Mary Newkirk
15. Birthplace Pennsylvania

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-18-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Ellicott City, Md.

18 (a) Funeral director Grant H. Hartz
(b) Address 814 W. 36 St.

19 (a) Filed APR 18 1947 (b) Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH April 12 1947, at 5:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 11 1947 to Apr. 12 1947 and that I last saw h im alive on Apr. 12 1947

Immediate cause of death	Duration
Cardiac Failure	2 wks
Due to Severe Generalized Arteriosclerosis	
Due to	
Other Conditions Cellulitis Left Leg	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operations:
of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. Fuller Wilson M. D.
Address City Hosp Date signed 4-17-47

X

VS 150

0822

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G50822

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 868 N Baltimore (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Louis LANG

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years	Months	Days	If less than one day
80			....hr. ....min.

9. Birthplace.....
(Town, county and state)
10. Usual Occupation.....
11. Industry or business

FATHER
12. Name.....
13. Birthplace

MOTHER
14. Maiden Name.....
15. Birthplace

16 (a) Informant.....
(b) Address

17 (a) Burial (b) Date thereof 4/18-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Johns Cemetery
Location Ellicott City Md
18 (a) Funeral director Frank H Seitz
(b) Address 714 N 36 St.
19 (a) APR 18 1947 (b) Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/8/47 19.... at 4.45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature John R Weirs M.D.
Medical Examiner.
Date signed 4/9/47

X

correct age is especially important

VS 151

0823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G50823

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4023 Belle Ave.
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4023 Belle Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALICE V. WRIGHT

3 (b) If veteran, name war	3 (c) Social Security Account No.
–	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Robert A. Wright
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 26, 1861

8. AGE: Years	Months	Days	If less than one day
85	11	21	hr. min.

9. Birthplace Thurmont, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Conrad A. Willhide
13. Birthplace Frederick Co., Md.

MOTHER
14. Maiden Name Harriett Wolfe
15. Birthplace Frederick Co., Md.

16 (a) Informant Miss Fannie C. Wright
(b) Address 4023 Belle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/18/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) APR 18 1947 (Date received by local registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16, 1947 at 5:30A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 2 1946, to Apr 16 1947, and that I last saw h[illegible] alive on Apr 15 1947.

Immediate cause of death: Myocardial insufficiency — Duration: 2 mos.
Due to: Hypertension + Arteriosclerosis — 15 yrs.
Due to: + age — [illegible]
Other Conditions: —
(Include pregnancy within 3 months of death)
Date of operation: —
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address 2200 Jarrett Blvd. Date signed 4/17/47

VS 150

Please write the cause of death clearly. Physicians: please write correct age is especially important.

0824

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G50824 / 8312

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1718 N. Wolfe St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 53

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1718 N. Wolfe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARIE RICHTER WEWERKA

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Adolph Wewerka
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 2, 1875

8. AGE: Years	Months	Days	If less than one day
72	3	14	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name August Richter
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mr. August H. Wewerka
(b) Address 3024 Iona Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/18/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date rec'd by Registrar APR 18 1947 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-16 1947, at 3:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-4- 1947, to 4-15- 1947, and that I last saw her alive on 4-15 1947.

	Duration
Immediate cause of death: Cerebral Thrombosis	12 days
Due to: Generalized arterio-sclerosis	2
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan C. Lang M. D.
Address 2117 Belair Rd Date signed 4-17-47

PLEASE WRITE plainly in the tables of death only. Physicians: please write the correct age is especially important.

50825

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

Registered No. 50825

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State D. C. (b) County.....
(c) City or town Washington (If outside city or town limits write RURAL and give town)
(d) Street No. 929 Massachusetts Ave NW (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country.....

3 (a) FULL NAME JAMES PAPPAS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
64			..... hr. ..... min.

9. Birthplace Greece (Town, county, and state)

10. Usual Occupation Waiter

11. Industry or business

FATHER
12. Name Pappas
13. Birthplace Greece

MOTHER
14. Maiden Name Stahtou Papadimetriou
15. Birthplace Greece

16 (a) Informant Mr. Louis L. Garman
(b) Address Preston at Maryland ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/19/47 (month) (day) (year)
(c) Cemetery or crematory Greek Orthodox
Location Evangelismos

18 (a) Funeral director Chas. J. Agnew General Home
(b) Address 118 W. Mt. Royal Ave.

APR 18 1947 (Date rec'd by registrar) Huntington Williams, M.D.

correct age is especially important

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1947 at 7.45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intracranial hemorrhage
Fractured left femur
~~Due to~~ Fractured left forearm
Fractured ribs
Fractured jaw
~~Other Conditions~~ Fractured right clavicle
Hemorrhage into left chest
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-15-47 at 6:40 P.M. Cal. Std.
(b) Where did injury occur? Race Rd. - Route #40
(c) Did injury occur at ~~home, on farm, industrial place~~, in public place? public place While at work? no
Means of injury Auto vs Truck

23. Signature George L. Merrill M.D. Medical Examiner.
Date signed 4/16/47

VS 181

50826

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G50826 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 706 N. Broadway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 706 N. Broadway (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME NICHOLAS T. GOURNARIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lilly Buckley Gounaris
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Oct. 22, 1877

8. AGE: Years	Months	Days	If less than one day
69	5	23	hr. min.

9. Birthplace Andros Greece
(Town, county, and state)
10. Usual Occupation Restaurateur
11. Industry or business

FATHER
12. Name Themistocles M. Gounaris
13. Birthplace Andros Greece

MOTHER
14. Maiden Name Catherine Helmis
15. Birthplace Andros, Greece

16 (a) Informant Themis Gounaris
(b) Address 706 N. Broadway

17 (a) Burial (b) Date thereof Apr. 18/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greek Orthodox
Location Evangelismos

18 (a) Funeral director George D. Agnew Funeral Home
(b) Address 112 W. Mt. Royal Ave
(Date) (Signature of registrar) Huntington Williams M.D.
APR 18 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 19 47 at 3 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/12 - 1947 to 4-15-1947
and that I last saw h[illegible] alive on 4-15 19 47

Immediate cause of death Respiratory failure -
Due to coronary occlusion
Due to arteriosclerosis
& cardiac decompensation
Other Conditions Treated at Hopkins 2 yrs - diagnosis
(Include pregnancy within 3 months of death)

Duration
24 hrs
7
-
-

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature S. C. Marcos M. D.
Address medical arts Bldg Date signed

PLEASE WRITE PLAINLY. Fill in all blanks. Be sure to write the cause of death correctly. Physicians: please write the cause of death correctly. correct age is especially important.

VS 150

0827.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

G50827.
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution:
Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1624 No Smallwood St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lena Winegrad

3 (b) If veteran, name war

3 (c) Social Security Account No.

Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1908

8. AGE: Years 39 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Mayer Berkowitz
13. Birthplace Russia

MOTHER
14. Maiden Name Dena
15. Birthplace Russia

16 (a) Informant Samuel Winegrad
(b) Address 1624 N Smallwood St

17 (a) Burial (b) Date thereof 4-18-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Ohai Israel
Location Southern Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1469 E Balto St

19 (a) (b)
(Signature of local registrar)

APR 18 1947

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/17 1947, at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 10 1947, to April 17 1947, and that I last saw h.e alive on April 17 1947.

Immediate cause of death	Duration
Acute Myelogenous Leukemia	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Ans above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Danny Rocker M. D.

Address Sinai Hospital Date signed 4/17/47

PLEASE WRITE CLEARLY. Physicians: please write correct age is especially important.

X

50828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G50828 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 3910 Chatham Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Pattinsorg (If outside city or town limits, write RURAL and give town)
(d) Street No. 3910 Chatham Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Regenia Weinberg

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years 78 | Months | Days | If less than one day hr. min.

9. Birthplace Germany (Town, county and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Jacob
13. Birthplace Germany

MOTHER 14. Maiden Name Bertha
15. Birthplace Germany

16 (a) Informant Herman Weinberg
(b) Address 3411 Holmes ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-18-47 (month) (day) (year)
(c) Cemetery or crematory Balto Hebrew
Location Belair Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 1459 E Balto St

APR 18 1947 Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-16-1947 at 8:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/11 1945 to 4/16 1947 and that I last saw h[illegible] alive on 4/16 1947.

Immediate cause of death: Acute pulmonary edema

	Duration
Due to: Myocardial insufficiency	1 hour
Due to: Arterio sclerosis	?
Other Conditions	7

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank Lerman
Address 4004 Liberty Heights Ave Date signed M. 4/17/47 D.

PLEASE WRITE PLAINLY with pencil or pen. Do not use ink. Do not write the causes of death clearly and legibly. correct age is especially important. Physicians: please write

0829

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

G50829
Registered No.

PLEASE WRITE PLAINLY, with ink. Physicians: please write the causes of death clearly and legibly. Give the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3640 Loyola Southway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3640 Loyola Southway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dora Adalman

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Hyman
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1875
8. AGE: Years 72 | Months | Days | If less than one day hr. min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Eli Lussman
13. Birthplace Russia

MOTHER
14. Maiden Name Sophia
15. Birthplace Russia

16 (a) Informant Hyman Adalman
(b) Address 3640 Loyola Southway
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-18-47 (month) (day) (year)
(c) Cemetery or crematory
Location Nebrego Friendship
18 (a) Funeral director Jack Lewis Inc
(b) Address 1492 E Dalto St
19 (a) Date received (Registrar) (b) Huntington Williams M.D. Registrar

APR 18 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-17-1947, at 11:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-14 1947 to 4-17 1947 and that I last saw her alive on 4-17 1947

Immediate cause of death: Pneumonia — Duration 3 days

Due to:

Due to:

Other Conditions: Hemiplegia, Diabetes Mellitus — Duration 5 days

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. A. Shaw M. D.
Address Temple Gardens Apt Date signed 4-17-47

109B

G50830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G50830 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3218 Sequoia Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3218 Sequoia Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ROY BYRON TURNER

3 (b) If veteran, name war

3 (c) Social Security Account No. 577-07-6639

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife CAROLYN O.
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) MAY 16-1891

8. AGE: Years	Months	Days	If less than one day
55	11	1	hr. min.

9. Birthplace SPRINGFIELD ILL. (Town, county, and state)
10. Usual Occupation AMERICAN TELEPHONE
11. Industry or business & TELEGRAPH CO.

MOTHER FATHER

12. Name JOHN TURNER
13. Birthplace SPRINGFIELD ILL.
14. Maiden Name LIONA DOUGLAS
15. Birthplace SPRINGFIELD ILL.

16 (a) Informant CAROLYN O. TURNER
(b) Address 3219 SEQUOIA AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4-19-47 (month) (day) (year)
(c) Cemetery or crematory WOOD LAWN
Location WOOD LAWN - MD.

18 (a) Funeral director Ellsworth Ormacost
(b) Address 3911 Liberty Heights Ave

APR 18 1947 (Date filed by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1947, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 23 1947, to April 17 1947, and that I last saw him alive on April 14 1947.

Immediate cause of death
(a) Coronary Thrombosis
Due to
Due to
Other Conditions - Coronary - Vascular Disease (Include pregnancy within 3 months of death)

Duration.	
(a)	

Date of operation
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide at M
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Fred L. Blumberg M.D.
Address 4101 Liberty Hts Date signed 4/17/47

correct age is especially important. Physicians, please

VS 3

50831 BC#D62119

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

182a Registered No. G50831

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3314 West Garrison Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME GAREY RESNICK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 13, 1946

8. AGE: Years | Months: 5 | Days: 4 | If less than one day: hr. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Bernard Resynick
13. Birthplace: New York

MOTHER
14. Maiden Name: Laurette Goldfadden
15. Birthplace: Baltimore

16 (a) Informant: Bernard Resnick
(b) Address: 3314- W. Garrison Avenue

17 (a) Burned (Burial, cremation, or removal) (b) Date thereof April 18 47 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Herring Run
Location: Bowleys Lane

18 (a) Funeral director: Sol Kurzman and Bro.
(b) Address: 1124-26 W North Ave

APR 18 1947 (Date rec'd by registrar) Huntington Williams, M.D.

correct age is especially important

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17, 1947, at 11 P.M.

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Asphyxia by suffocation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-17-47 at about 10.10 P. M.
(b) Where did injury occur? 3314 W. Garrison Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury: Smothered with bedclothes

23. Signature: George L. Merrill M.D. Medical Examiner.
Date signed 4/18/47

VS 191

X

0832

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G50832 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address New Howard Hotel
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8 N. Howard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Siegel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 70 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace New York N.Y.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Louis Siegal

13. Birthplace Russia

MOTHER 14. Maiden Name Esther Lecavitt

15. Birthplace Russia

16 (a) Informant Henry Siegel

(b) Address Rochester Court Apts

17 (a) Burial (b) Date thereof (month) (day) (year)
(Burial, cremation, or removal)

(c) Cemetery or crematory Bnai Israel Cemetery

Location Southern Ave

18 (a) Funeral director Sol Levinson & Bros.

(b) Address 1124-26 W North Ave.

APR 18 1947 Huntington Williams M.D.
(Date received by registrar) Registrar

correct age is especially important. Any...

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/16 1947, at 7:30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature A. A. Schmuke M.D.
Medical Examiner.

Date signed 4/17/47

X

0833

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH ✓ 83a

G50833
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland ✓
(b) Street address 6420 Reinterstown Road
(c) Hospital or institution: The Keton Institute
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-7-23
(e) Length of stay in Baltimore (yrs., mos., or days) 4-7-23

2. USUAL RESIDENCE OF DECEASED:
(a) State Pennsylvania (b) County Dauphin
(c) City or town Harrisburg
(If outside city or town limits, write RURAL and give town)
(d) Street No. 511 N. Maclay St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sister Mary Anthony Desmond

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race white

6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 7-17-1868

8. AGE: Years 78 | Months 9 | Days 0 | If less than one day hr. min.

9. Birthplace Renovo, Pennsylvania
(Town, county, and state)

10. Usual Occupation music teacher

11. Industry or business

FATHER
12. Name John Desmond
13. Birthplace Ireland

MOTHER
14. Maiden Name Johanna Haley
15. Birthplace Ireland

16 (a) Informant The Keton Institute
(b) Address 6420 Reinfretown Rd., Balto. 15, Md.

17 (a) Burial (b) Date thereof 4-18-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Cross
Location Harrisburg Pa.

18 (a) Funeral director S. Siwart Monroe Co.
(b) Address 1028 Work Ave.

APR 18 1947 Huntington Williams, M.D.

VS 150

PLEASE WRITE PLAINLY, with ... correct age is especially important. Physicians: please write the ... the cause of death clearly and ...

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-17- 1947, at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1942 to 4/17 1947.
and that I last saw h[illegible] alive on 4/17 1947.

Immediate cause of death: Arteriosclerosis — Duration: 1 day

Due to: ?

Due to:

Other Conditions: psychosis with arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury?

23. Signature Ramsay F. Boyd M. D.
Address 33 W. Preston St. Date signed

0834

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1483

Registered No. C50834

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1710 Darley Ave.
(c) Hospital or institution:
a15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1710 Darley Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie A. (Minna) Rode

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife John Rode
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1886

8. AGE: Years	Months	Days	If less than one day
60	7	10	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Christian Schuetze
13. Birthplace Germany

MOTHER
14. Maiden Name Louisa Muller
15. Birthplace Germany

16 (a) Informant John Rode
(b) Address 1710 Darley Ave.-13

17 (a) Burial (b) Date thereof 4/19/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.

APR 18 1947 (a) (b) Huntington Williams M.D.
(Date rec'd by Registrar) (Registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16, 1947, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 10 1944, to Apr 16 1947, and that I last saw her alive on April 16 19 47

Immediate cause of death Carcinoma Uterus — Duration 1½ yrs

Due to

Due to

Other Conditions Secondary anemia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alice Thelen M. D.
Address 4116 Northern Parkway Date signed 4/17/47

PLEASE PRINT — correct age is especially important. Physicians: please write

X

50835

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50835 Registered No. 13B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto Genl Hosp 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and name town)
(d) Street No. 1106 N Gilmor St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William E. Woods

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	M.

6 (b) Name of husband or wife Gladys
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-21-06

8. AGE: Years	Months	Days	If less than one day
39	11	28	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation unemployed
11. Industry or business

FATHER
12. Name Mecidemus Woods
13. Birthplace Va

MOTHER
14. Maiden Name Mary V. Chase
15. Birthplace Md.

16 (a) Informant Gladys Woods
(b) Address 1106 N. Gilmor St.

17 (a) B (Burial, cremation, or removal) (b) Date thereof 4-19-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location City

18 (a) Funeral director Samuel H. Sulkerin Jr.
(b) Address 1011 N. Arlington Ave

APR 18 1947 (Date rec'd by Registrar) (b) Huntington-Williams Mfg. Co.

VS 151

correct age is especially important

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1947, at 1:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were

IMMEDIATE CAUSE OF DEATH Pulmonary tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William E. Pelgrim M.D. Medical Examiner
Date signed April 18, 1947

50836

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G50836 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fallsway & Fayette St.
(c) Hospital or institution:
Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4 S. Monroe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Landon C. Miles – LANDON C. MILES.

3 (b) If veteran, name war: Second World War
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Married

6 (b) Name of husband or wife: Louise E. Miles
6 (c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) June 12-1909

8. AGE: Years	Months	Days	If less than one day
37 58	10	4	hr. min.

9. Birthplace Baltimore, Md. (Town, county and state)
10. Usual Occupation Filling Sta. Operator
11. Industry or business Pepco Oil Co.

FATHER
12. Name Elmer Miles
13. Birthplace Md.

MOTHER
14. Maiden Name —
15. Birthplace Md.

16 (a) Informant Louise E. Miles
(b) Address 4 S. Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/18/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director F. B. Wightman Sons
(b) Address 300 Eutaw Place

19 (a) Date received by registrar APR 18 1947 Huntington Williams M.D.

correct age is especially important. Information...

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-16-1947, at 3 A. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary artery disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury.

23. Signature Earl R. Royer M.D. Medical Examiner.
Date signed 4-16-47

837

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G50837

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor Ave. & Dukeland St.
(c) Hospital or institution:
West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da's
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 858 West 33rd St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE W. PHIPPS "GEORGE W. PHIPPS"

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-02-4110

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Sarah J. Phipps
6 (c) If alive, give age D. years

7. Birth date of deceased (mo., day, yr.) 11-5-1883

8. AGE: Years	Months	Days	If less than one day
63	5	12	hr. min.

9. Birthplace A.A. County, Md.
(Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Bernard N. Phipps
13. Birthplace Maryland

MOTHER
14. Maiden Name Laura Overten
15. Birthplace Wilmington, Delaware

16 (a) Informant Talbert W. Phipps
(b) Address 856 West 33rd. Street

17 (a) Burial (b) Date thereof Apr. 20/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Maryland

18 (a) Funeral director [illegible]
(b) Address 1300 Eutaw Place

19 APR 18 1947 [illegible]
(Date rec'd by registrar)

VS 150

PLEASE WRITE PLAINLY, with ... correct age is especially important. Physicians: please write the causes of death clearly and ...

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/17 1947, at 10:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/15 1947 to 4/17 1947 and that I last saw him alive on 4/17/47 19

Immediate cause of death CEREBRO VAS-CULAR ACCIDENT — Duration

Due to

Due to

Other Conditions BRONCHO PNEUMONIA

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] by [illegible]
Address 3008 W. North Ave. Date signed M/D. 4/17/47

0838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C50838

131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 916 N. Collington Ave.
(c) Hospital or institution:
7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
3
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 916 N. Collington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna M. Cvach

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife James Cvach
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Jan. 8, 1892

8. AGE: Years	Months	Days	If less than one day
55	3	7	....hr. ....min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph J. Pazourek
13. Birthplace Bohemia

MOTHER
14. Maiden Name Catherine Vanicek
15. Birthplace Bohemia

16 (a) Informant James Cvach
(b) Address 916. N. Collington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-18-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Frank Cvach & Son
(b) Address 900. N. Chester St.

APR 18 1947

(a) Date received by registrar (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1947, at 4.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946, to April 15 1947, and that I last saw h[illegible] alive on 4-15 1947.

Immediate cause of death	Duration
Pulmonary Edema and Bronchopneumonia	6 hrs
Due to Hypertension and Cardiovascular Renal Disease	Several years
Due to Cerebral Hemorrhage Left Hemiplegia	5 days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Katherine H. BorKovich M. D.
Address 11 E. Chase St. Date signed 4-16-47

Baltimore-2 X

PLEASE WRITE the CAUSES OF DEATH correctly and fully. Omit words like "chronic," "acute," "old," "senile," "complications," "exhaustion," "failure," "infection," "disease," "poisoning," "hemorrhage," "shock," "paralysis," "ulcer," "tumor," "abscess," "cancer," "fracture," "injury," "inflammation," "necrosis," "gangrene," "thrombosis," "embolism," "aneurism," "rupture," "stricture," "obstruction," "perforation," "peritonitis," "septicemia," "pyemia," "uremia," "anemia," "debility," "convulsions," "coma," "delirium," "dementia," "aphasia," "hypostasis," "edema," "syncope," "asphyxia," "atrophy," "hypertrophy," "degeneration," "calculus," "carcinoma," "sarcoma," "multiple," "primary," "secondary," "general," "local," "partial," "total," "unknown," "cause unknown," "not known," "not determined," "not ascertained," "undiagnosed," "no doctor," "no medical attendance," "found dead," "sudden," "suddenly," "instantaneous," "natural," "natural causes," "unavoidable," "accidental," "accidentally," "suicide," "suicidal," "homicide," "homicidal," "self-inflicted," "self-administered," "criminal," "while insane," "while intoxicated," "while asleep," "during sleep," "during epileptic seizure," "during labor," "during pregnancy," "during childbirth," "during abortion," "during operation," "during anesthesia," "during surgical procedure," "during medical treatment," "during hospitalization," "during confinement," "during imprisonment," "during execution," "during war," "during peace," "during riot," "during strike," "during accident," "during fire," "during explosion," "during collision," "during derailment," "during wreck," "during drowning," "during electrocution," "during suffocation," "during starvation," "during exposure," "during freezing," "during heat," "during cold," "during weather," "during storm," "during flood," "during earthquake," "during volcano," "during tornado," "during hurricane," "during cyclone," "during typhoon," "during blizzard," "during avalanche," "during landslide," "during mudslide," "during snowslide," "during rockslide," "during icefall," "during waterfall," "during drowning," "during submersion," "during immersion," "during asphyxiation," "during strangulation," "during hanging," "during suffocation," "during starvation," "during exposure," "during freezing," "during heat," "during cold," "during weather," "during storm," "during flood," "during earthquake," "during volcano," "during tornado," "during hurricane," "during cyclone," "during typhoon," "during blizzard," "during avalanche," "during landslide," "during mudslide," "during snowslide," "during rockslide," "during icefall," "during waterfall," "during drowning," "during submersion," "during immersion," "during asphyxiation," "during strangulation," "during hanging," correct age is especially important. Physicians: please write

0839

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G50839 Registered No. 166

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Philadelphia (If outside city or town limits, write RURAL and give town)
(d) Street No. 715 N. 8th Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Henry WILLIAMS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife Julia Palmer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 27, 1912

8. AGE: Years	Months	Days	If less than one day
34	5	18	hr. min.

9. Birthplace Jarboro, S.C. (Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER
12. Name Richard Williams
13. Birthplace Jarboro, S.C.

MOTHER
14. Maiden Name Cornelia Perry
15. Birthplace Jarboro, S.C.

16 (a) Informant Richard Williams Jr.
(b) Address 206 N. Stricker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-19-1947 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs. Katie R. Walker
(b) Address 322 N. Schroeder St.

19 (a) Filed APR 18 1947 (b) by Huntington Williams M.R. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14, 1947 at 10 23 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet-wound of brain
Intracranial hemorrhage

Due to

Other Conditions Bullet-wound of rt. thigh
Bullet-wound of left thigh.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-14-47 at P. M.
(b) Where did injury occur? 626 W. Redwood St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? NO
(d) Means of injury Firearms

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 4/15/47

VS 151

Correct age is especially important. Page

50840

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83B

Registered No. C50840

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave
(c) Hospital or institution:
Sinai Hosp. 27
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 16 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3507 W. Garrison Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Salvatore Pallini

3 (b) If veteran, name war none

3 (c) Social Security Account No. 214-03-4874

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name [redacted] wife late Angiolina

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 18 1880

8. AGE: Years	Months	Days	If less than one day
66	7	27	hr. min.

9. Birthplace Pitigliano Grosseto (Italy)
(Town, county, and state)

10. Usual Occupation Presser

11. Industry or business Baltimore Coat Shop

FATHER
12. Name Pietro Pallini
13. Birthplace Italy

MOTHER
14. Maiden Name Rosa Fabrizzani
15. Birthplace Italy

16 (a) Informant Renato Pallini (Son)
(b) Address 3507 W. Garrison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 19/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ New Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Frank Della Rocca
(b) Address [redacted] Morley St.

19 APR 18 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

V S 150

PLEASE WRITE PLAINLY. Physicians: please write the correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/16 1947 at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/21 1947 to 4/16 1947 and that I last saw h[redacted] alive on 4/15 1947.

Immediate cause of death Cerebral Embolus — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [redacted]
Address Sinai Hosp Date signed 4/16 M.D.

X

G50811 IN-

BALTIMORE CITY HEALTH DEPARTMENT

109823 CERTIFICATE OF DEATH ✓97

Registered No. G50811

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days

(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 307 East St.

(e) Citizen of foreign country? Syria ? (If rural give location) (Yes or No)

If yes, name country

3 (a) FULL NAME Vito Fragale

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 30 1869

8. AGE: Years	Months	Days	If less than one day
78	2	17	hr. min.

9. Birthplace Syria ? (Town, county, and state)

10. Usual Occupation Fruit Merchant

11. Industry or business

FATHER

12. Name ?

13. Birthplace ?

MOTHER

14. Maiden Name ?

15. Birthplace ?

16 (a) Informant Baltimore City Hospitals

(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 19 47 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Rd. Baltimore

18 (a) Funeral director Frank Della Rose

(b) Address 52 W. Hoffman St

19 (a) APR 18 1947 (Registrar's signature) Wilhelmina [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16th 1947 19 at 7.43 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 12th 1947 to Apr. 16 1947 and that I last saw him alive on Apr. 16/ 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Generalized Arteriosclerosis	
Due to	
Other Conditions Malnutrition	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature W. Doyle Wallace M. D.

Address B C H Date signed 4-17-47

PLEASE WRITE PLAINLY. Physicians: please write the cause of death clearly. Also correct age is especially important.

VS 150

50842

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 171a

G50842 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 15-13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2508 Shirley Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alfonso Perella

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	Widowed

6 (b) Name of husband or wife Late Adelina
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28, 1874

8. AGE: Years	Months	Days	If less than one day
72	8	20	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation retired
11. Industry or business Tailor

FATHER 12. Name Domenico A. Perella
13. Birthplace Italy

MOTHER 14. Maiden Name Antonia D'Abruzzo
15. Birthplace Italy

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-19-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Gleisle Rd

18 (a) Funeral director Frank D. Albert
(b) Address 52 N. Monroe St

19 (a) APR 18 1947 (Date rec'd by registrar) Tomlinson Williams (b) Registrar

correct age is especially important

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-17- 1947 at 12 15 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fracture of Skull & Intracranial Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 5/1

(a) Date of injury 4/17/47 M.
(b) Where did injury occur? Baltimore - Fremont St
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Struck by Street-Car

23. Signature Earl H. Ryan M.D. Medical Examiner.
Date signed 4-17-47

VS 191

50843

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. C50843

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 569 Preastman St
(c) Hospital or institution:
14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 569 Preastman
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME: ROSA DICKERSON INGRAM

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex: F | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife: John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/27/1881

8. AGE: Years 65 | Months 11 | Days 13 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Moses Dorsey
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden Name Mary
15. Birthplace Carroll, Co. Md.

16 (a) Informant Margaret Bacon
(b) Address 569 Preastman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/18/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N. Carrollton Ave

19 APR 18 1947 (Date rec'd by Registrar) (b) Huntington Ave Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH April 14 1947, at 1:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/10/47 19.. to 4/14 1947
and that I last saw h alive on 4/13 1947

Immediate cause of death: Lobar Pneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
4 days
12 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. N. Dalton M. D.
Address 1715 Pennsylvania Ave Date signed 4-17-47

PLEASE PRINT — Physicians: please write the correct age is especially important.

VS 150

50844

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. C50811

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 902 W. Lexington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 902 W? Lexington (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME AGNES GARRETT

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. NONE

4. Sex: F | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: WIDOWED

6 (b) Name of husband or wife: JAMES
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/ 1 /1876

8. AGE: Years 70 | Months 6 | Days 15 | If less than one day ..... hr. ..... min.

9. Birthplace Saulsbury, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name ALFRED LAFIELD
13. Birthplace Md.

MOTHER
14. Maiden Name Eliz. Ranns
15. Birthplace Md

16 (a) Informant Pauline Welch(Niece)
(b) Address 118 Catherine St.(Salsbury Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/20/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A.A.County Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N Carrollton Ave

19 (a) APR 18 1947 Registrar for Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/16/47 19..., at 9A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/7-47 19... to 4/16 1947
and that I last saw h[illegible] alive on 4/12 1947

Immediate cause of death: Uremia — Diabetes Mellitus — Duration: 22d

Due to: — Duration: 1 hr

Due to: —

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. J. Hatch
Address [illegible] Date signed 4/17/47

Physicians: please write carefully and correct age is especially important.

VS 150

X

50845

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

Registered No. G50845

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1333 Bolton St D.O.A.
(c) Hospital or institution: 11

(d) Length of stay in hospital or inst. (yrs., mos., or days) ....
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ....
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1333 Bolton St (If rural give location)
(e) Citizen of foreign country? .... (Yes or No)
If yes, name country ....

3 (a) FULL NAME Lucy B. Pyles

3 (b) If veteran, name war	3 (c) Social Security Account No.
✓	✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Elagatt Pyles
6 (c) If alive, give age .... years

7. Birth date of deceased (mo., day, yr.) Dec 9 1898

8. AGE: Years	Months	Days	If less than one day
48	3 4	28	.... hr. .... min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation ~~Retd~~
11. Industry or business Dress Shop

FATHER
12. Name George Barry
13. Birthplace Balto.

MOTHER
14. Maiden Name Lucy Small
15. Birthplace Balto.

16 (a) Informant Leslie T. Hartlove
(b) Address 619 Darcy Ave. Joliet Ill

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 18/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave

18 (a) Funeral director John D. Mitchell Sons
(b) Address 1900 Eutaw Place

19 (a) APR 18 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

correct age is especially important

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/16 1947, at 3:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxia due to
Illuminating gas
Due to ....

Other Conditions ....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4/16/47 at about 2 P.M.
(b) Where did injury occur? 1333 Bolton St
(c) Did injury occur at home, on farm, industrial place, in public place? a home While at work? No
(d) Means of injury Gas inhaling from 5 burner

23. Signature J. P. Sulmirski M.D.
Medical Examiner.
Date signed 4/17/47

50846

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 170c

Registered No. G50846

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5314 Calvert
(c) Hospital or institution:
Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Washington
(c) City or town Hagerstown Maryland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 249 Bryan Place (If rural give location)
(e) Citizen of foreign country? U.S. (Yes or No)
If yes, name country

3 (a) FULL NAME Harry M. Logan

3 (b) If veteran, name war J | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Mrs Harry M. Logan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 18 1884

8. AGE: Years 62 | Months 11 | Days 30 29 | If less than one day ..... hr. ..... min.

9. Birthplace Penn.
(Town, county, and state)

10. Usual Occupation –

11. Industry or business –

MOTHER | FATHER
12. Name Simon Logan
13. Birthplace Penn.
14. Maiden Name Anna Lock
15. Birthplace Penn

16 (a) Informant wife
(b) Address

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (month) (day) (year)
(c) Cemetery Hagerstown Md
Location

18 (a) Funeral director John A Mitchell, Sons
(b) Address 1900 Eutaw Place

APR 18 1947 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-17 1947, at 5:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-12 1947, to 4-17 1947, and that I last saw him alive on 4-17 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Metastatic Cancer Lung	
Due to Abdomen + chest injury	
Other Conditions Fracture of femur	

(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence 4-12-47 at 3 P M
(c) Where did injury occur? Towson (City or town) Balto. (County) MD (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... (Specify type of place) While at work? .....
(e) Means of injury Run over by auto car
23. Signature Chester I Mace M. D.
Address Union Memorial Hosp. Date signed 4-17-47

Wm. S. Hilfield MD
1947
George G. Merrill MD. X

G50817

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

163#

Registered No. G50817

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8m
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1829 E 29th St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME August Freyer (FREYER)

3 (b) If veteran, name war: W
3 (c) Social Security Account No. 218-12-2274

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Ida
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Aug 1864
8. AGE: Years 82 | Months 8 | Days | If less than one day hr. min.
9. Birthplace: Baltimore Md (Town, county, and state)
10. Usual Occupation: Picture Frame Maker
11. Industry or business: A H Grape Co

FATHER
12. Name: Unknown Freyer
13. Birthplace: Unknown

MOTHER
14. Maiden Name: ?
15. Birthplace:

16 (a) Informant: James R Freyer
(b) Address: Cowpdale Md

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 4/19/47 (month) (day) (year)
(c) Cemetery or crematory: Ft Lincoln
Location: Bladensburg Md

18 (a) Funeral director: Wilson & Son
(b) Address: 2172 Pennsylvania Ave

19 (APR 18 1947) (Date rec'd by registrar) Huntington Williams, M.D.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1947, at 3:45 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Asphyxiation due to Illuminating Gas.

Due to:

Other Conditions: Atherosclerotic Cardiovascular Disease
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury April 17 1947 3:45 P M.
(b) Where did injury occur? 1829 E 29th St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury: Open burner on gas range

23. Signature: Fred Williams Jr Kelly M.D. Medical Examiner
Date signed: April 18, 1947

X

50848 Seaman :- S.S. New Texas

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. C50818

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Hilton street
(c) Hospital or institution:
City morgue
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County Australia
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Reginald T. Burton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years	Months	Days	If less than one day
43 42			hr. min.

9. Birthplace Bristone Australia
(Town, county, and state)

10. Usual Occupation Seaman

11. Industry or business

MOTHER FATHER

12. Name B Burton

13. Birthplace Bristone Australia

14. Maiden Name Unknown

15. Birthplace Australia

16 (a) Informant Mr Mulvone Griffith

(b) Address Gillett Bldg Morgue

17 (a) Buried (b) Date thereof 4/19/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore Md

18 (a) Funeral director Wilson & Son

(b) Address 1219 E Fayette St.

19 (a) APR 18 1947 (b) Huntington Williams, M.D.
(Date received by registrar)

correct age is expensive supposed

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17, 1947 at 10 45 M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☒ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of Skull with intracranial Hemorrhage

Due to See amended certificate - Reverse side. 1

Other Conditions Lacerated scalp

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 4/17/47 at 24/1 M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Cyril L Royer M.D.
Medical Examiner.

Date signed 4/17/47

G50849

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G50849

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 935 North Hill Rd.
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 935 North Hill Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Finick Thomas

3 (b) If veteran, name war: N
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Joseph N. Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 19th 1869

8. AGE: Years	Months	Days	If less than one day
77	7	28	hr. min.

9. Birthplace Pittsburgh Pa.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own Home

FATHER
12. Name Anthony Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Marie Swartland
(b) Address 935 North Hill Rd.

17 (a) Removal (b) Date thereof 4/19/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Uniondale
Location Pittsburgh Pa.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st.

19 (a) APR 18 1947 (b)
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17th 1947, at 1 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 6 apr. 1947 to 17 apr. 1947, and that I last saw her alive on 16 APR. 1947.

Immediate cause of death	Duration
Due to Hypertensive Cardio Vascular renal disease	2 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lloyd E. Taylor M. D.
Address 3902 Clemens Date signed 17 apr. 1947

VS 150

correct age is especially important. Physicians: please w

G50850

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 72a ✓

Registered No. G50850

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 924 N Luzerne Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 924 N Luzerne Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances M. Frank

3 (b) If veteran, name war: No.
3 (c) Social Security Account No.: None

4. Sex: F. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: George D.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2 1863

8. AGE: Years	Months	Days	If less than one day
84	1	14	hr. min.

9. Birthplace: Balto (Town, county, and state)
10. Usual Occupation
11. Industry or business: At Home

FATHER
12. Name: Anthony Beil
13. Birthplace: Germany

MOTHER
14. Maiden Name: ?
15. Birthplace: Germany

16 (a) Informant: John A Frank
(b) Address: 924 N. Luzerne Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 19 47 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: 4300 Belair Rd

18 (a) Funeral director: Mat. Hite Undertaking Co
(b) Address: 37 S Amity St

19 (a) APR 18 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1947 at 5 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 2 1947 to April 16 1947 and that I last saw h[illegible] alive on Apr. 16 1947

Immediate cause of death	Duration
(a) Senile changes	5 yrs +
(b) Cerebral arteriosclerosis	- 1 wk.
Due to (c) Pulmonary Hypostasis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: [illegible] M. D.
Address: 325 Portman Pk Av Date signed 4/17/47

PLEASE WRITE PLAINLY. Physicians: please write the correct age is especially important.

VS 150

X

G50851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

Registered No. G50851

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: South Baltimore Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1234 Hull Street
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME MICHAEL MARKOWITZ

3 (b) If veteran, name war

3 (c) Social Security Account No. –

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced. –

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 19, 1939

8. AGE: Years 8 | Months 2 | Days 28 | If less than one day .....hr. .....min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation
11. Industry or business School - Child

FATHER
12. Name Stanley Abremski
13. Birthplace Baltimore

MOTHER
14. Maiden Name Anna Markle
15. Birthplace Penn. Hanover

16 (a) Informant Stanley Abremski
(b) Address 1234 Hull St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 19, '47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Annapolis Blvd.

18 (a) Funeral director Edgar F. Dell.
(b) Address 1501 E Fort Ave.

19 (a) (Date received by Registrar) APR 18 1947 (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/16 1947, at 8:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Drowning

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-16-47 at 7 P. 24/1 M.
(b) Where did injury occur? Foot of Hull St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Fell into water while playing

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 4/17/47

X

correct age is especially important

G50852

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164a

Registered No. G50852

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address EASTERN AVENUE
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) UNKOWN

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3141 Elliott St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME HARRY CASHNER

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	DIVORCED

6 (b) Name of husband or wife UNKOWN
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 8 - 15 - 1893

8. AGE: Years	Months	Days	If less than one day
53	8	3 2	— hr. — min.

9. Birthplace OHIO (Town, county, and state)
10. Usual Occupation INTERIOR DECORATOR
11. Industry or business —

FATHER
12. Name DAVID CASHNER
13. Birthplace OHIO

MOTHER
14. Maiden Name JENNIE ?
15. Birthplace OHIO

16 (a) Informant MRS. RAYMOND HARPER
(b) Address 3141 ELLIOTT ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4 - 21 - 47 (month) (day) (year)
(c) Cemetery or crematory DAYTON CEMETERY
Location DAYTON OHIO

18 (a) Funeral director Lieb & Zeiler Inc.
(b) Address 403 S. WOLFE ST.

19 (a) APR 18 1947 (b) Huntington-Williamsport, Md.

correct age is especially important

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-17- 1947, at 1 30 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation by hanging

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-17-47 at 1 P. M.
(b) Where did injury occur? 3141 Elliott St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? NO
(d) Means of injury: Hanged self by rope from ceiling

23. Signature George W. Merrill M.D.
Medical Examiner.
Date signed 4/18/47

50853

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93

Registered No. G50853

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Knights of Pl. Home
(c) Hospital or institution: Madeira & Cathedral Hts
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 146 E. Ellwood Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS R. SAVAGE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Dec'd.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 29 - 1879

8. AGE: Years	Months	Days	If less than one day
67.	4	17	hr. min.

9. Birthplace Ohio
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER 12. Name Thomas Savage
13. Birthplace Ohio

MOTHER 14. Maiden Name Annie MacDonald
15. Birthplace Ohio

16 (a) Informant Mrs. Ruth Crawford-niece
(b) Address 114-58-124th St Queens Pk

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 (month) 9 (day) 47 (year)
(c) Cemetery or crematory Lorraine
Location Winters Mill Rd.

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. WOLFE ST.

19 (a) (b) Huntingtown Wilkinson, MD

APR 18 1947

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1947, at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from December 1945 to April 16 1947, and that I last saw h[illegible] alive on April 16 1947.

Immediate cause of death	Duration
Arteriosclerotic Cardio-Vascular Disease	2 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. O. Thomas, M. D.
Address 11 E. Chase St Date signed 4-17-47

PLEASE WRITE PLAINLY. Physicians: please write correct age is especially important.

X

50851 Bothmer ✓ 50854

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. 50854

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 19 S. Payson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 19 S. Payson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John F. Bothmer

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-27-8257

4. Sex M. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary Bothmer

6 (c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) Feb. 1 1869

8. AGE: Years 78 | Months 2 | Days 16 | If less than one day 15 hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Frederick Bothmer

13. Birthplace Germany

MOTHER 14. Maiden Name Mary Kitzenmeyer

15. Birthplace Germany

16 (a) Informant Mrs Mary Bothmer

(b) Address 19 S. Payson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-19-47 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore

18 (a) Funeral director Frederick A. Cole

(b) Address 1111 W. Lombard St

19 (a) APR 18 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1947, at 6:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/10 1947, to 4/16 1947, and that I last saw h alive on 4/15 1947.

Immediate cause of death: Hypostatic Pneumonia — Duration 24 hrs

Due to: Intercapsular fracture C.V. Disease

Due to:

Other Conditions: Fractured Left hip

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 20/3

(a) Accident, suicide, or homicide Accident

(b) Date of occurrence March 9 1947 5:30 P.M.

(c) Where did injury occur? Home (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? at Home (Specify type of place) While at work? No

(e) Means of injury Fell at home (Fell down cellar steps)

23. Signature C. P. Fulcrinske M. D.

Address 1945 W Balto St Date signed

PLEASE WRITE PLAINLY. Use ink. Do not use pencil. Be sure to fill in the blanks. Be sure to give the causes of death. Be sure to correct age is especially important. Physicians: please write distinctly.

VS 150

George G. Merrill MD 4/16/47

G50855

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G50855

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.O.A.
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 25 N. Exeter St
(If rural give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country born in USA

3 (a) FULL NAME James Miles

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 22-1873

8. AGE: Years	Months	Days	If less than one day
73	4	26	hr. min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation Ret. Iron Molder

11. Industry or business

FATHER
12. Name John Miles
13. Birthplace Ireland

MOTHER
14. Maiden Name Ann Hassard
15. Birthplace Ireland

16 (a) Informant Miss Nellie Miles
(b) Address 508 W 139th St N.Y. City

17 (a) Burial (b) Date thereof 4-21-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Pine Grove Cem
Location Waconia Conn.

18 (a) Funeral director Geo. E. Bayer Jr
(b) Address 1512 Baltimore St Hunting for Williamsport

19 APR 18 1947
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/15 1947, at 1st P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature R. J. Stolen Jr M.D.
Medical Examiner.

Date signed 4/16/47

correct age is especially important

VS 181

G50856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G50856

AB-109642

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13days.
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Howard Lascallett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 17- 1872

8. AGE: Years 75 | Months 2 | Days 29 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER: 12. Name John Lascallett
13. Birthplace Maryland

MOTHER: 14. Maiden Name Mary Abel
15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/19/47 (month) (day) (year)
(c) Cemetery or crematory Pipe Creek
Location Linwood Md.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) 4 18 1947 (b) Huntingtown Millington, Md.
(Signature of local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1947, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-3- 1947, to 4-16 1947, and that I last saw him alive on 4-16 1947.

Immediate cause of death: Cardiac failure — Duration: 7

Due to arteriosclerotic heart disease

Due to

Other Conditions (1) Bronchopneumonia — 2days
(2) Thrombus in right auricle
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy see above

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edwin C. Evans M. D.
Address Balto. City Hospitals Date signed 4-16-47

PLEASE WRITE PLAINLY. Write the cause of death clearly and correct age is especially important. Physicians: please write

VS 150

50857. 509 019 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 1172 Registered No. 50857.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 66 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 418 E. Pennsylvania Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oliver Johnson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4 Sex: Male | 5 Color or race: Black | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-10-99

8. AGE: Years 45 | Months 2 | Days 24 | If less than one day ___hr. ___min.

9. Birthplace W. Va.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER

12. Name Ike Johnson

13. Birthplace W. Va.

MOTHER

14. Maiden Name Gertrude Johnson

15. Birthplace P

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Loc. Johns Hopkins Medical School APR 16 1947

18 (a) Funeral director Commissioner of Health

(b) Address

(c) [illegible] Williams M.D.
(By registrar)

APR 8 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-6-47 at 9.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-30-1947 to 4-6 1947 and that I last saw h[illegible] alive on 4-6-1947

Immediate cause of death	Duration
Subdiaphragmic abscess	2 Mos
Due to Gastric fistula	2 Days
Due to Perforated Stomach ulcer	9 wks (a)
Other Conditions Duplo Hepatic Colitis	

(Include pregnancy within 3 months of death)

Date of operation 1/30/47, 2/19/47, 3/20/47

Major findings of operation: Same

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard C. Clay

Address Johns Hopkins Hosp. Date signed 4/7/47

Please see that correct age is especially important. Physicians: please write plainly.

VS 130

X

C50858

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. C50858

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 Rogers Ave
(c) Hospital or institution: Home for Aged of Methodist Church
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 Rogers Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Heller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Edna Heller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 12 1861

8. AGE: Years	Months	Days	If less than one day
85	6	5	hr. min.

9. Birthplace Fredericksburg Va
(Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business Home for Aged

FATHER
12. Name David Heller
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Bauman
15. Birthplace Germany

16 (a) Informant Rondo Methodist Home
(b) Address 2211 Rogers Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/21/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Balto Co. Md.

18 (a) Funeral director Wm Cook Inc
(b) Address 217 St. Paul St

19 (a) APR 18 1947 (Date rec'd by registrar) (b) Huntington Woods, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17th 1947, at 5 35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 14 April 1947, to 17 April 1947, and that I last saw him alive on 16 April 1947.

Immediate cause of death	Duration
Myocardial Insufficiency	
Due to Arteriosclerotic Cardiovascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hyman L. Warsaw M.D.
Address 3900 Alameda Blvd Date signed 18 Apr. 1947

PLEASE WRITE THE CAUSES OF DEATH CLEARLY. Physicians: please write correct age is especially important.

VS 150

Dr. Gage 709 N. Broadway 4/6 1619 J

50859

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No. G50859

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2926 Eudowood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Greenmount
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rural
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Lauer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed or divorced~~: Married

6 (b) Name of ~~husband or~~ wife: Florence Lauer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 16th 1877

8. AGE: Years 69 | Months 5 | Days 0 | If less than one day ... hr. ... min.

9. Birthplace Md. (Town, county and state)

10. Usual Occupation Farmer - Butter & Egg

11. ~~Industry or~~ business Own

FATHER — 12. Name Unknown Lauer

13. Birthplace "

MOTHER — 14. Maiden Name "

15. Birthplace "

16 (a) Informant Dr. Alex. S. Gage

(b) Address 709 N. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/19/47 (month) (day) (year)

(c) Cemetery or crematory Green Mount

Location Balto. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul St

19 APR 18 1947 (b) ... Registrar

VS 150

PLEASE WRITE PLAINLY with pen or pencil. Physicians: please write correct age in years. Also fill in items 20 to 23 if you are especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16th 1947, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/10 1947 to 4/17 1947, and that I last saw h[illegible] alive on 4/14/47 19...

Immediate cause of death	Duration
Heart Diseased	
Due to	
Due to Heart Failure	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alex S. Gage M. D.

Address 709 N Broadway Signed 4/16/47

X

50860 AB-104118

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50860

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7mos-18days
(e) Length of stay in Baltimore (yrs., mos., or days) 6yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. City Jail (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Garnett Fridley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife: Minnie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept- 16-1907

8. AGE: Years 39 | Months 7 | Days 1 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Fridley
13. Birthplace Ga. or Va.

MOTHER
14. Maiden Name Virginia Rose
15. Birthplace Va.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4/18/47 (month) (day) (year)
(c) Cemetery or crematory Clifton Forge, Va
Location Clifton Forge, Va

18 (a) Funeral director Wilson Bolt Co
(b) Address 1217 Pont St

19 (a) APR 18 1947 (Date rec'd by registrar) Huntington Williams, Md.

MEDICAL CERTIFICATION PM

20. DATE OF DEATH April 17 1947, at 5.05 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-29- 1946, to 4-17 1947, and that I last saw h im alive on 4-17 1947.

Immediate cause of death: Pulmonary Tuberculosis, Far-advanced. — Duration: 4 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Refused

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Hunt
Address Balt. City Hosp. Date signed 4-18-47

PHYSICIAN

Underline the cause to which death should be charged statistically.

Please write the cause of death correct age is especially important. Physicians: please write

VS 150

X

G50861

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 163H

Registered No. G50861

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) One
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 915 E. Pratt St
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME FRANCIS LAKE WISE

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War.	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Josephine. Wise
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Apr. 11-1896

8. AGE: Years	Months	Days	If less than one day
51	-	4	..... hr. ..... min.

9. Birthplace Cecil Co. Md.
(Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business

FATHER
12. Name George G. Wise
13. Birthplace Elkton Md

MOTHER
14. Maiden Name Margaret N. McGee
15. Birthplace Hillsgrove St Marys County

16 (a) Informant Josephine Wise
(b) Address 916 E. Pratt St.

17 (a) Burial (b) Date thereof 4/19/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Md. National
Location Frederick ave

18 (a) Funeral director Wendel & Hoppel
(b) Address 841 S. Highland Ave

19 (a) Filed APR 18 1947 Huntington Williams, M.D.
(Registrar's signature)

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1947 at 5:35 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH.....
Carbon monoxide poisoning,
due to inhalation of
Due to illuminating gas.
.....
Other Conditions.....
.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-15-47 at 7:30 P.M.(?)
(b) Where did injury occur? 915 E Pratt St
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? not
(d) Means of injury [illegible]

23. Signature George L. Pfeiffer M.D.
Medical Examiner.
Date signed 4/16/47

50862 AB- 109340

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C50862

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 266days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 712 S. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Fletcher Hill

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Sep.

6 (b) Name of husband or wife Roxie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18- 1888 or July 18 1888

8. AGE:	Years	Months	Days	If less than one day
or 58	58	9 mo	0 0	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Wesley Hill
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Strong
15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 21-1947 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Chapel
Location Near Aberdeen Md

18 (a) Funeral director Henry Fanning & Sons
(b) Address Aberdeen Md

19 APR 19 1947 (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18- 1947, at 5.10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-22 1947 to 4-18 1947, and that I last saw him alive on 4-18 1947.

Immediate cause of death	Duration
Cardiac failure	
Due to Arteriosclerotic cardio vascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: ASCVD

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Doyle Waldron M. D.
Address B. C. H. Date signed 4-18-47

PLEASE WRITE CLEARLY. Physicians: please write the cause of death in terms which describe the underlying pathological condition. Indicate the correct age is especially important.

G50863

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

G50863 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2641 Frederick Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2641 Frederick Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Clara Anderson

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: John Anderson
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) January 27 1886

8. AGE: Years 61 | Months 2 | Days 21 | If less than one day ____ hr. ____ min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business: Home

FATHER
12. Name: Mordecai Hillman
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Elizabeth V. Phillips
15. Birthplace: Maryland.

16 (a) Informant: Maude J. Myers
(b) Address: 2637 Frederick Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-19-47 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore, Maryland

18 (a) Funeral director: Geo. L. Schwab
(b) 2196 Frederick Ave.

19 (a) APR 19 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17, 1947, at 5:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1 1947 to 4/17 1947, and that I last saw h[illegible] alive on 4/17 1947.

Immediate cause of death	Duration
Carcinoma of rectum	1 yr.
Due to	
Due to	
Other Conditions Uremia (acute)	2 days

(Include pregnancy within 3 months of death)

Date of operation May 1, 1946
Major findings of operation: Carcinoma of rectum
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Benjamin Keller M. D.
Address 1030 Wilkens ave
Date signed 4/17/47

PLEASE WRITE PLAINLY. Be sure to give the causes of death clearly and legibly. Be sure to correct age is especially important. Physicians: please write the

G50864

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G50864

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1819 Eutaw Place
(c) Hospital or institution:
14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1819 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Zipporah Beauchamp

3 (b) If veteran, name war: W
3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of husband ~~or wife~~: Capt. Chas. T. Beauchamp
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1st 1861

8. AGE: Years 85 | Months 9 | Days 16 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER
12. Name Severn Crabwell
13. Birthplace Md

MOTHER
14. Maiden Name Mary Muir
15. Birthplace Md.

16 (a) Informant Mrs Elsie Shad
(b) Address 1819 Eutaw Place

17 (a) Burial (b) Date thereof 4/19/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Parkwood
Location Parkville Md.

18 (a) Funeral director Williams Cook Inc.
(b) Address 1217 E. Paul St.

19 APR 19 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

PLEASE WRITE IN INK and use words in full. Physicians: please write correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17th 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1947, to April 17 1947, and that I last saw her alive on 4-17 1947.

	Duration
Immediate cause of death: Cerebral Hemorrhage Right side of Head.	2 days
Due to: General Debility	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos. H. Ruckert M. D.
Address 1939 Edmondson Date signed 4-18-47

VS 150

G50865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G50865 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 245 Benzinger Road (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank L. Marten

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-10-5723

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Hilda

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 25 1892

8. AGE: Years 54 | Months 9 | Days 22 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Ind Mechanic

11. Industry or business Metal Work

FATHER
12. Name John Martin
13. Birthplace Ireland

MOTHER
14. Maiden Name Matilda McCadden
15. Birthplace Unknown

16 (a) Informant Mrs Hilda A. Martin
(b) Address 245 Oakley Village

17 (a) Burial (Burial, ~~cremation~~, or removal) (b) Date thereof 4/21/47 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

19 (a) APR 19 1947 (Date rec'd by Registrar) Huntington Williams, M.D.

VS 181

correct age is especially ...

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1947, at 6 45 P M

21. I certify that I took charge of the remains described above, held an Autopsy/Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Reilich M.D. (Medical Examiner)
Date signed April 18, 1947

50866

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G50866

PLEASE WRITE PLAINLY with pen or pencil and make no erasures. Write the causes of death clearly and legibly. Use only standard abbreviations. Do not use ditto marks. Be sure to answer all questions, and if any cannot be answered write "unknown" or "none" where necessary. Do not write in the space below. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 160 N. Potomac St
(c) Hospital or institution: [illegible] 6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 160 N. Potomac St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wm Lotterer

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Louisa Lotterer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 20 - 1879

8. AGE: Years 68 | Months 2 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Kasper Lotterer
13. Birthplace Germany

MOTHER 14. Maiden Name ?
15. Birthplace

16 (a) Informant Mrs. Louisa Lotterer
(b) Address 160 N. Potomac St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 21 47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location "

18 (a) Funeral director Philip Herwig Sons.
(b) Address 2024 Orleans St.

19 APR 19 1947 (Date rec'd by registrar) Burlington for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1947, at 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 16 1947, to April 17 1947.
and that I last saw h[illegible] alive on April 17 1947.

Immediate cause of death	Duration
Arterio-Sclerosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Eugene Geller, M.D.
Address 2737 Eastern Ave Date signed 4/18/47

VS 150

0867

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G50867

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1225 St. Mathews St
(c) Hospital or institution: 5

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1225 St. Mathews St (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Scranton

3 (b) If veteran, name war (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col	Widow

6 (b) Name of husband or wife Leon Scranton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1849

8. AGE: Years	Months	Days	If less than one day
48			hr. min.

9. Birthplace St Johns N. C. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

MOTHER | FATHER
12. Name Walter Outlaw
13. Birthplace N. C.
14. Maiden Name Cecelia Anderson
15. Birthplace N. C.

16 (a) Informant Clarence Williams
(b) Address 1225 St. Mathews St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/19/47 (month) (day) (year)
(c) Cemetery or crematory Int Cultery
Location Ebron O. Wilson

18 (a) Funeral director
(b) Address 1000 Brantly Ave

19 (Date rec'd by registrar) APR 19 1947 Huntingtown Williamsburg, Md.

PLEASE WRITE CLEARLY. Give the cause of death so that physicians can correctly code it. Physicians: please write the cause of death so that it is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1947, at 10:A M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 14 1947 to Apr 16 1947, and that I last saw h[illegible] alive on Apr 14 1947

Immediate cause of death	Duration
Myocardial failure	
Due to Bronchopneumonia	4 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. C. Burwell M.D. M. D.
Address 171 Augusta Date signed 4-17-47

VS 150

X

50868

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

Registered No. G50868

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) B-0-A
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 540 Wilson Pl
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Mamie Baker Beatrice

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Married

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1920

8. AGE: Years	Months	Days	If less than one day
27			..... hr. ..... min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name John Owens
13. Birthplace U. S.

MOTHER
14. Maiden Name Cicero Henson
15. Birthplace Baltimore Md

16 (a) Informant James Baker
(b) Address 540 Wilson St

17 (a) Burial (b) Date thereof April 19, 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn Md
18 (a) Funeral director Elroy B Wilson
(b) Address 1510 Orleans St
19 (a) APR 19 1947 Huntington Williamsport Md
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-12-1947, at 1.50 AM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Hemorrhage due to multiple
stab wounds of the chest
Due to wounding the lung.

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-12-47 at ? 1.30 A.M.
(b) Where did injury occur? Carey - Lanvale Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Sharp instrument

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 4-12-47

correct age is especially important

VS 151

G50869

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

Registered No. G50869

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 401 W. Lex Holly
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State or country Distrito Colombia
(c) City or town Washington (If outside city or town limits, write RURAL and give town)
(d) Street No. ~~2804 — 14th St. N.W.~~ 2804 — 14th St. N.W. (If in institution, give usual residence)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Lanham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Blanche Hunt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 27-1880

8. AGE: Years 67 | Months 0 | Days 22 | If less than one day ____ hr. ____ min.

9. Birthplace Va. (Town, county and state)

10. Usual Occupation Real Estate oper.

11. Industry or business self

FATHER 12. Name John C. Lanham

13. Birthplace Va.

MOTHER 14. Maiden Name Ann E. Follin

15. Birthplace Va

16 (a) Informant Blanche Lanham

(b) Address 2804-14th St. N.W. Wash. D.C.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4/19/47 (month) (day) (year)

(c) Cemetery or crematory

Location Washington D.C.

18 (a) Funeral director S. H. Hines

(b) Address 2001 14th St. Washington D.C.

19 APR 19 1947 (Date rec'd by registrar) (b) Huntington Williams Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/19/47 19 at 12:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John E. Davis M.D. Medical Examiner.

Date signed 4/19/47

X

VS 151

correct age is essentially important

650870

CWK-65937 or 65939

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

650870 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5- 11- 1-
(e) Length of stay in Baltimore (yrs., mos., or days) 22 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Caton & Wilkins Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Moran

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Hasewill
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23-1885

8. AGE: Years	Months	Days	If less than one day
61	10	20	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Samuel Ball
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Albay
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 4/18/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loyola Metairie
Location Lorman Street Road

18 (a) Funeral director J. J. Faherty Sons
(b) Address 1518 Light St.

19 (a) APR 19 1947 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1947, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 12 1941 to April 13 1947, and that I last saw h 97 alive on Apr. 13 1947.

Immediate cause of death Cardiac failure — Duration

Due to Myocardial insufficiency

Due to A.S.C.V.D.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: A.S.C.V.D.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Doyle Waldron M.D.
Address B. C. H. Date signed 4-18-47

PLEASE WRITE PLAINLY. Physicians: please write the correct age is especially important.

VS 150

50871 BC#B-7552 **BALTIMORE CITY HEALTH DEPARTMENT** **CERTIFICATE OF DEATH** 59 Registered No. C50871

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland Gen'l Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Min.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Min.

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County
(c) City or town Staunton (If outside city or town limits, write RURAL, and give town)
(d) Street No. 227 N. Jefferson St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Hayes

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6, 1947

8. AGE: Years	Months	Days	If less than one day
			hr. 5 min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Virginia M. Hayes
15. Birthplace Virginia

16 (a) Informant Virginia Hayes.
(b) Address 227 N. Jefferson St, Staunton, Va

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location
18 (a) Funeral director
(b) Address
19 Date received by Local Registrar APR 19 1947 Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1947, at 5:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 6 1947 to April 6 1947, and that I last saw him alive on April 6 1947.

Immediate cause of death	Duration
Prematurity.	5 Min.
Due to Spontaneous Abortion	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. A. Cranmore M.D.
Address Maryland Gen'l Hosp Date signed 16 April 47

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and in detail. correct age is especially important.

VS 150

50872

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G50872

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2241 Annapolis Road.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2241 Annapolis Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Ellen Schull

3 (b) If veteran, name war: --
3 (c) Social Security Account No. --

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife George A. Schull
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) May 26, 1875

8. AGE: Years	Months	Days	If less than one day
71	10	21	....hr. ....min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Nicholas Fischbaugh
13. Birthplace Maryland.

MOTHER
14. Maiden Name Marhha Adams
15. Birthplace Maryland

16 (a) Informant George A. Schull
(b) Address 2241 Annapolis Road.

17 (a) Burial (b) Date thereof 4/21/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.

19 APR 19 1947 (b) Huntington Millikan, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17, 1947, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 8 1946 to April 17 1947, and that I last saw her alive on April 15 1947

Immediate cause of death	Duration
Coronary occlusion	1 day
Due to Arteriosclerotic Heart Disease	unknown
Due to	
Other Conditions Pernicious Anemia	1 year

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nathan Racusin M.D.
Address 206 S. Gilmor St Date signed 4-18-47

V S 150

X

Please write plainly. Physicians: please write correct age is especially important.

50873

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

Registered No. C50873

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1358 n. Fremont ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 15 years.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1358 n (If rural give location) Fremont ave
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nadie Camm

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife William Camm.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 18, 1902

8. AGE: Years 45 | Months - | Days 29 | If less than one day hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name Nelson Walker

13. Birthplace N. C.

MOTHER 14. Maiden Name —

15. Birthplace —

16 (a) Informant William Camm

(b) Address 1358 N. Fremont ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-19-47 (month) (day) (year)

(c) Cemetery or crematory Arlington

Location Md

18 (a) Funeral director Geo. E. Nelson

(b) Address 1303 Pressman St

19 APR 19 1947 (Registered by Registrar) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1947, at 4:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-22-1947 to 4-16-1947 and that I last saw h[illegible] alive on 4-15-1947.

Immediate cause of death	Duration
Congestion Heart Failure	
Due to Mitral Regurgitation	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wayland D. Jones M.D.

Address 1700 N. Fremont Ave Date signed 4/18/47

PLEASE WRITE PLAINLY. Fill in all blanks by typewriting or with pen and ink. Physicians: please write the cause of death in such a way that the correct age is especially important.

50874

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 50874

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1120 Poplar Grove St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr.
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1120 Poplar Grove St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry E. Levy.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Kate Henry E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 7, 1862

8. AGE: Years	Months	Days	If less than one day
84	7	9	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation
11. Industry or business Retired

FATHER
12. Name Alexander D. Levy.
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Emily F. Mackenzie
15. Birthplace Baltimore Md

16 (a) Informant Mrs John L. Garrison
(b) Address 1120 Poplar Grove St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/21/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location 4300 Old Frederick Rd.

18 (a) Funeral director John F. Boyce & Son
(b) Address 20-07 Pulaski St.

19 (a) APR 19 1947 (Date rec'd by registrar) (b) Huntington W. Jones, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/16/1947, at 8:30 P. M.

21. I certify that death occurred on the date above stated that I attended deceased from 4/12/1947 to 4/16/1947, and that I last saw h[illegible] alive on 4/16/1947.

Immediate cause of death	Duration
Cerebral Thrombosis	5 days
Due to Arteriosclerosis	
Due to	
Other Conditions Hypostatic pneumonia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James E. Reynolds
Address 521 Medford Bldg. Date signed 4/17/47

VS 150

PLEASE WRITE PLAINLY. Please see that the certificate is complete and correct. Be sure that age is especially important. Physicians: please write the cause of death clearly.

Schneider

C50875

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 194a

C50875 4c

Registered No. C50875

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Ave
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 46 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1933 Griffin Avenue (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James L Schneider

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-03-5240

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Eulalia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 17-1889

8. AGE: Years 57 Months 4 Days 1 If less than one day hr. min.

9. Birthplace Union Bridge Md (Town, county, and state)

10. Usual Occupation Merchant Estimator

11. Industry or business

FATHER
12. Name [illegible]
13. Birthplace Union Bridge

MOTHER
14. Maiden Name Amy Nusbaum NUSBAUM
15. Birthplace Union Bridge

16 (a) Informant Eulalia A Schneider
(b) Address 1933 Griffin Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/21/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Mt Olivet Md

18 (a) Funeral director Edward Lowlow
(b) Address Reisterstown Road Blvd

19 (a) APR 19 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/18/1947, at 5:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/14/1947 to 4/18/1947 and that I last saw h[illegible] alive on 4/18/1947.

	Duration
Immediate cause of death (a) Heart failure	
Due to Coronary occlusion Posterior basal and	4 days
Due to myocardial degeneration	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. E. Gonzalez
Address Maryland Gen Hosp Date signed 4/18/47

PLEASE WRITE PLAINLY, with pen and ink; please write the causes of death clearly and correct age is especially important. Physicians: please write

VS 150

50876

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1313

Registered No. 50876

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4503 Eastern ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4503 Eastern ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ellen May Harris

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female.	White.	Married

6 (b) Name of husband or wife George W. Harris
6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) Sept. 16. 1912

8. AGE: Years	Months	Days	If less than one day
34.	7	13	hr. min.

9. Birthplace Washington County Pa
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles P. Campbell.
13. Birthplace Pa.

MOTHER
14. Maiden Name Maud Norstell
15. Birthplace Boyerstown Pa.

16 (a) Informant George W. Harris
(b) Address 4503 Eastern ave

17 (a) Burial (b) Date thereof 4/19/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Mathias
Location Edmondson Ave.

18 (a) Funeral director Turnbull & Sheppard
(b) Address 312 E. Highland Ave

19 (a) APR 19 1947 (b) Transcribed from Baltimore Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-17- 1947, at 7A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-19- 1946 to 4-17- 1947. and that I last saw her alive on 4-16- 1947

Immediate cause of death	Duration
Pulmonary Tb	2yrs +
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature N. J. Danda M. D.
Address 3218 Eastern ave Date signed 4-18-47

PLEASE WRITE PLAINLY. Physicians: please write the cause of death so that correct age is especially important.

VS 150

50877
AB-109983

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50877

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2610 Masseth Ave.-Edgemere
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Charlotte ~~Thirsten~~ Thurston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 11- 1946

8. AGE: Years	Months	Days	If less than one day
	8	7	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Milton ~~Thirsten~~ Thurston
13. Birthplace Virginia

MOTHER
14. Maiden Name Frances Burch
15. Birthplace Virginia

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) BURIAL (b) Date thereof 4 21 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE.
18 (a) Funeral director JOHN F. DENNY, INC.
(b) Address 715 LIGHT ST.
19 APR 19 1947 (b) ~~Huntington~~ Williamsport
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 19 47, at 9.25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-17 19 47 to 4-18 1947.
and that I last saw h. ~~er~~ alive on 4-18- 19 47.

Immediate cause of death	Duration
Pneumococcal meningitis	1 da.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Wilson E. Hughes M. D.
Address Balto City Hosp. Date signed Apr 19 47

PLEASE WRITE WITH PEN AND INK. Physicians: please write the causes of death carefully and correct any wrong statement. Information is especially important.

VS 150

0878

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. C50878

PLEASE WRITE PLAINLY, with pen and ink. Physicians: please write the causes of death clearly and legibly. Use only standard abbreviations. Do not use ditto marks. Be sure that every question is answered. Please see that your certificate is correct and complete. Omissions and errors cause unnecessary correspondence, and sometimes result in the return of the certificate, which is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 631 N. Lakewood Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 631 N. Lakewood Avenue (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN KROLL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Emma (nee Semmler)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1878

8. AGE: Years	Months	Days	If less than one day
68	9	25	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business General Ship Repair

FATHER
12. Name William Kroll
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Emma Semmler Kroll
(b) Address 631 N. Lakewood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/19/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) ~~APR 19 1947~~ April 19 1947 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1947, at 4 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 17 1947, to Apr. 17 1947, and that I last saw h. alive on Apr. 17 1947.

Immediate cause of death	Duration
Myocarditis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. Dettmar M. D.
Address 701 N. Linwood ave. Date signed April 19-47

X

G50879

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G50879 Registered No. 47c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hosp. 28
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40m
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Washington
(c) City or town Clearspring
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME VIRGINIA Lee SEIBERT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/11/1868

8. AGE: Years	Months	Days	If less than one day
79	1	8	hr. min.

9. Birthplace Clearspring, Washington, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Lancelot J. Feight
13. Birthplace Washington Co., Md.

MOTHER
14. Maiden Name Mary Rice
15. Birthplace Clearspring, Md.

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof 4 22 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Paul
Location Near Wagners from Clearspring

18 (a) Funeral director E. M. Porter and Son
(b) Address 305 North Potomac St.

19 (a) APR 20 1947 (b) Hagerstown, Md.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1947, at 8:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/23 1947 to 4/19 1947 and that I last saw h.er alive on 4/19 1947.

Immediate cause of death respiratory failure — Duration

Due to — pneu

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. J. North Jr. M.D.

Address Bon Secours Hosp. Date signed 4/19/47

PLEASE WRITE PLAINLY. Fill the blanks with the correct facts as specially important. Physicians: please write

G50880

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

10613

G50880 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4102 Maine Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4102 Maine Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rachael Abrams

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Max
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1877
8. AGE: Years 70 Months Days If less than one day hr. mjn.
9. Birthplace Lith (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Arthur
13. Birthplace Lith

MOTHER
14. Maiden Name Pena
15. Birthplace Lith

16 (a) Informant Samuel Abrams
(b) Address 1520 E Balto St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-20-47 (month) (day) (year)
(c) Cemetery or crematory Rozedale
Location Phila Pk & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1519 E Balto St

APR 20 1947 Huntington Williamsville, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-19-1947, at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 12 1947 to April 19 1947, and that I last saw h.. alive on April 19 1947

Immediate cause of death: Acute myocardial Insufficiency — Duration: 7 days
Due to Arteriosclerosis — 20 Years
Due to
Other Conditions Emphysema + Chronic Bronchitis — 10 Years
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jack Cohen M. D.
Address 1804 Eutaw Place, Date signed 4/19/47

93E

G50881

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 136

G50881 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 233 Douglas Court
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 233 Douglas Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amelia Bell Williams Hammond

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col	M

6 (b) Name of husband or wife William Hammond
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 8, 1899

8. AGE: Years	Months	Days	If less than one day
48	2	7	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Stephen Wallace
13. Birthplace Md

MOTHER
14. Maiden Name Mary S. Dennis
15. Birthplace Md

16 (a) Informant William Hammond
(b) Address 233 Douglas Court

17 (a) Burial (b) Date thereof April 20, 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1510 Orleans St

19 (a) 4-20 1947 (b)
(Date rec'd by registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-15 1947, at 2.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/12 1947 to 4/15 1947 and that I last saw h[illegible] alive on 4/14/47 1947.

Immediate cause of death	Duration
(a) Pulmonary Tuberculosis	7
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 600 Carroll Bldg Date signed 4/16/47

PLEASE WRITE PLAINLY. Fill in all blanks with the best information obtainable. Be sure that the cause of death is correctly stated. Care in especially important. Physicians: please write legibly.

G50883
AB-47750

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G50883 Registered No. 1356

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7yrs-7mos-23days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 601 Gutman Ave.
(e) Citizen of foreign country? (If rural give location) (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Huber

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Delia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 8- 1883

8. AGE: Years	Months	Days	If less than one day
64	2	9	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name William Huber
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Murr
15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-21-47 (month) (day) (year)
(c) Cemetery or crematory Cathedral — City —
Location

18 (a) Funeral director Wiedefeld & Son.
(b) Address Freemont Ave & 22nd St.

19 1947 (Date rec'd by registrar) Washington Williams M.D. Registrar

MEDICAL CERTIFICATION PM

20. DATE OF DEATH April 17- 1947, at 12:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-24- 1939 to 4-17 1947, and that I last saw him alive on 4-17- 1947

Immediate cause of death	Duration
Pyelonephritis & Cortical Abscess	3 wks
Due to Pyelitis & Severe Cystitis	
Due to Enlarged Prostate Hypertrophy & Urinary Retention	
Other Conditions Severe arterio sclerotic C-V disease & Left Hemiplegia	

(Include pregnancy within 3 months of death)
Date of operation 4-16-47
Major findings of operation: Suprapubic Cystostomy & Severe Cystitis
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Butler M.D.
Address City Hospitals Date signed 4-18-47

PLEASE WRITE AND CHECK FOR CORRECTNESS. Physicians: please write correct age is especially important.

VS 150

G50883

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G50883

PLEASE WRITE PLAINLY, with pencil or pen. Do not abbreviate the causes of death except under approved conditions. Answer all questions as correctly and completely as possible. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 918 N. PATTERSON PARK AVE.
(c) Hospital or institution: 7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County BALTIMORE
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 918 N. PATTERSON PK AVE
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH TERRY (TARASEWICZ)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOWED

6 (b) Name of husband or wife JOSEPH TERRY

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ~~7~~ 1876

8. AGE: Years	Months	Days	If less than one day
71 ~~4556~~	3		hr. min.

9. Birthplace VILNA - LITHUANIA
(Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business —

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name WALUNAS
15. Birthplace LITHUANIA

16 (a) Informant JOSEPH TERRY
(b) Address 903 S. PACA ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/22/47 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Holy Cedar
Location

18 (a) Funeral director THOS. J. KENNY, INC.
(b) Address 1600 HOLLINS ST

19 (a) [illegible] (b) [illegible] Registrar

APR 20 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1947, at 6-15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 10 1947 to April 19 1947, and that I last saw h[illegible] alive on April 18 1947

Immediate cause of death — Duration

Coronary Thrombosis — 9 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide NO
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Pokorny

Address 2200 E Madison St X Date signed M D 4/19/47

G50884

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

G50884 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Providence Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1725 N. Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James A. Jordan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb-12-1917

8. AGE: Years 30 | Months 2 | Days 6 | If less than one day hr. min.

9. Birthplace Oakville St. Marys Co, Md
(Town, county, and state)

10. Usual Occupation Labor.

11. Industry or business

FATHER
12. Name Louis Jordan
13. Birthplace Md

MOTHER
14. Maiden Name Rose L. Jordan
15. Birthplace Md

16 (a) Informant Lawrence Forbes Jordan
(b) Address Oakville, Md.

17 (a) Burial (b) Date thereof 4-22-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Josephs
Location Mangum, Md

18 (a) Funeral director W. C. Mattingly Sons
(b) Address Leonardtown, Md

APR 20 1947 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

correct age is especially important.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18, 1947 at 5.25 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Bullet wound of heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 4/18/47 5 A. M.
(b) Where did injury occur? 921 Wilmer Lane
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearm

23. Signature Earl L. Royer M.D.
Medical Examiner.

Date signed 4/18/47

X

C50885

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. C50885

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3904 Delcton Dr.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3907 Delcton Dr.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katheryn Hogan Unglenk

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	W.

6 (b) Name of husband or wife William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 31-1866

8. AGE: Years	Months	Days	If less than one day
80	3	20	hr. min.

9. Birthplace New York City
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER — 12. Name	Michael Kelly
FATHER — 13. Birthplace	Ireland
MOTHER — 14. Maiden Name	Jane Clarke
MOTHER — 15. Birthplace	Ireland

16 (a) Informant Mildred Middleton

(b) Address 3907 Delcton Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/23/47 (month) (day) (year)

(c) Cemetery or crematory New York

Location

18 (a) Funeral director Wm Cobb Sons

(b) Address 127 St Paul St

19 (c) [illegible] (Date filed by registrar) Huntington for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1947, at 3a M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946, to 4/19 1947, and that I last saw h[illegible] alive on 4/19 1947.

Immediate cause of death	Duration
Septicemia	3 days
Due to Celulitis of neck	4 days
Due to	
Other Conditions Arteriosclerosis Senility	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos E. Cook M. D.

Address 3629 Edmondson Date signed 4/20/47

PLEASE WRITE PLAINLY. correct age is especially important. Physicians: please write

APR 21 1947

VS 150

152

C50886 C.

102173

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. C50886

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 24
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 136 E. Gittings St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Riggins, Louise

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	NHB

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May- 14- 1878

8. AGE: Years	Months	Days	If less than one day
68	11	5	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Robb.
13. Birthplace Germany

MOTHER
14. Maiden Name Lena Weamert
15. Birthplace Germany

16 (a) Informant Records Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/23/47 (month) (day) (year)
(c) Cemetery or crematory London Pk. Cem
Location Balto

18 (a) Funeral director Lem Cook Inc
(b) Address 32 St Paul

19 APR 21 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

PLEASE WRITE LEGIBLY. Physicians: please write the causes of death clearly, correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19- 1947, at 4.30p M

21. I certify that death occurred on the date above stated; that I attended deceased from June 18 1946, to April 19 1947, and that I last saw h. er alive on April 19 19 47.

Immediate cause of death	Duration
Respiratory failure	
Due to Bronchopneumonia	
Due to	
Other Conditions Myocardia infarction Diabetes Mellitus Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Bronchopneumonia Myocardial infarction Arteriosclerosis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Doyle Waldron M. D.
Address B. C. H. Date signed 4-20-47

VS 150

107

Robbins

G50887 Aff F63653

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G50887

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs. - 4 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1622 N. Eutaw Place
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Jean Robbins

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 1, 1942

8. AGE: Years 4 | Months 4 | Days 16 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Baltimore Md.
(Town, county, and state)

10. Usual Occupation None
11. Industry or business

FATHER
12. Name Walter Robbins
13. Birthplace Maryland

MOTHER
14. Maiden Name Martha Gerber
15. Birthplace Maryland

16 (a) Informant Mrs. Robbins
(b) Address 1622 N. Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/21/47 (month) (day) (year)
(c) Cemetery Loraine Presbyterian
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 APR 21 1947 (Date filed by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1947, at 7:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 11 1947 to April 17 1947, and that I last saw h.r alive on April 17 1947.

Immediate cause of death: Pneumonia
Peritonitis

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 4/12/47

Major findings of operation:

of autopsy:

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward J. Burkhart M. D.
Address Md. Gen'l Hosp. Date signed Apr 17, 47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Fill in the causes of death clearly and legibly. Give correct age in years, months, days, or hours. Physicians: please write the cause of death in such a way that it can be easily understood. Omissions and errors will delay burial. Your correct age is especially important.

VS 180

50888

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH V 186a

Registered No. G50888

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County
(c) City or town Middle Burg (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gerald B. Webb Jr

3 (b) If veteran, name war: World War II
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1907

8. AGE: Years 40 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Colorado (Town, county, and state)
10. Usual Occupation Managing Editor
11. Industry or business "The Chronicle"

FATHER
12. Name Dr. Gerald Webb
13. Birthplace Byce Va

MOTHER
14. Maiden Name unknown
15. Birthplace "

16 (a) Informant Hospital Records
(b) Address

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Apr 21 1947 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore Md

18 (a) Funeral director Henry W Jenkins & Bro
(b) Address 1014 Guilford Ave Baltimore Md

19 (a) [illegible] (b) Lauriston Williams M.D.
(Date rec'd by registrar) Registrar

APR 21 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/19 1947, at 8:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Fractured Skull
Crushed Chest
Due to
Other Conditions Multiple Fractures
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4/19/47 Baltimore City M.
(b) Where did injury occur? Worthington Valley Md
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? No
(d) Means of injury Fall off horse - dragged
23. Signature C. S. Palmer Crouse M.D.
Medical Examiner.
Date signed 4/19/47

correct age is especially important. Typewrite or print plainly.

VS 181

50889 ZAKOSCIELNY

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. C50869

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fulton and Madison
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 57

2. USUAL RESIDENCE OF DECEASED:
(a) State Md, (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 535 Fulton Rose St 535 S. Rose St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Casimir Zakoscielny

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-09-8195

4. Sex MALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of ~~husband or~~ wife LOUISE

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) JUNE 13, 1889 ?

8. AGE: Years	Months	Days	If less than one day
57 ?	10	6	....hr. ....min.

9. Birthplace POLAND (Town, county, and state)

10. Usual Occupation LABOR

11. Industry or business

MOTHER'S FATHER

12. Name SEBASTIAN ZAKOSCIELNY

13. Birthplace Poland

MOTHER'S MAIDEN

14. Maiden Name JOZEFA JACINSKA

15. Birthplace POLAND

16 (a) Informant LOUISE ZAKOSCIELNY

(b) Address 535 S. Rose Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-22-47 (month) (day) (year)

(c) Cemetery or crematory St Stanislaus

Location Baltimore Md.

18 (a) Funeral director Kease & Weber

(b) Address 705 E Baltimore St

19 (Date rec'd by registrar) APR 21 1947 Huntington Williamson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/19/47, at 6:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/17/47 19 47 to 4/19/47 19 47.
and that I last saw h..... alive on ..... 19.....

Immediate cause of death Heart failure

Due to A.C.V. Disease & Decompensation (Cor. Sclerosis)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C.C. Gonzalez

Address Maryland General Hosp Date signed 4/19/47

PLEASE WRITE PLAINLY, with unfading ink. Fill in all items. Be sure to write the causes of death clearly and accurately. Give correct age in especially important. Physicians: please write your name and address.

VS 150

X

G50890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G50890

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 714 N. Fremont (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter Young
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	N	Widower

6 (b) Name of husband or wife Louise
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/28/73

8. AGE: Years	Months	Days	If less than one day
74	2	21	hr. min.

9. Birthplace Columbia S.C. (Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business Garage

FATHER
12. Name Unknown
13. Birthplace " " "

MOTHER
14. Maiden Name " " "
15. Birthplace " " "

16 (a) Informant Dora Stanley
(b) Address 1222 W. Lanvale St

17 (a) B (Burial, cremation, or removal) (b) Date thereof 4-23-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location Balto. Co.

18 (a) Funeral director Samuel W. Sullivan Jr.
(b) Address 1944 Pulaski Hwy

19 (a) APR 21 1947 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/18 1947, at 9:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/18 1947 to 4/18 1947, and that I last saw h[illegible] alive on 4/18 1947.

Immediate cause of death Arteriosclerotic Heart Disease

Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. H. Barnard M.D.
Address Provident Hospital Date signed 4/21/47

PLEASE WRITE PLAINLY, with ink. Give the causes of death clearly and accurately. Physicians: please write the correct age is especially important.

C50891

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. C50891

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2011 Madison Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2011 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES E. DORSEY

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 15, 1877

8. AGE: Years	Months	Days	If less than one day
69	6	4	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Janitor
11. Industry or business

FATHER
12. Name Thomas Dorsey
13. Birthplace Md.

MOTHER
14. Maiden Name Julia Cassell
15. Birthplace Md.

16 (a) Informant Mrs. Julia Dorsey
(b) Address 2011 Madison Ave.

17 (a) Burial (b) Date thereof April 23, 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) APR 21 1947 Huntington Williams, M.D.
(Date received by registrar) (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1947, at 4A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/18 1947 to 4/19/47
and that I last saw h alive on 4/19/47

Immediate cause of death — Duration

Due to Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 4/19/47

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Cecil Corner M. D.
Address 1131 Harlem Ave Date signed 4/19/47

PLEASE WRITE PLAINLY, WITH INK. Do not write the causes of death directly and vaguely. Physicians: please write correct age is especially important.

VS 150

G50892

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G50892

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 month 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 month 14 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County Westmoreland Co.
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Armstead Gatewood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race Negro

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-15-1884

8. AGE: Years 63 Months Days 3 If less than one day hr. min.

9. Birthplace Westmoreland Co. Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name — Gate Wood

13. Birthplace Westmoreland Co. Va.

MOTHER 14. Maiden Name Fannie Johnson

15. Birthplace Westmoreland Co. Va.

16 (a) Informant Eva. Maddox

(b) Address 1466 Riggs Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/21/47 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location West Balto. Md.

18 (a) Funeral director Metropolitan Funeral Home

(b) Address 927 N. Mount St. Balto.

19 APR 21 1947 Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-18 1947 at 8:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-4 1947 to 4-18 1947, and that I last saw h[illegible] M alive on 4-18 1947

Immediate cause of death Uremia — Duration

Due to Acute Nephritis

Due to

Other Conditions 2nd degree burn Left Arm
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 3-25-47 at ? M
(c) Where did injury occur? Westmoreland Co. Va. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home While at work? no working
(Specify type of place)
(e) Means of injury Burned with hot grease while frying potatoes

23. Signature R. L. Jackson / Twiltz M. D.

Address Provident Hosp. Date signed 4-22-47

George G. Merrill MD X 112

PLEASE WRITE PLAINLY, with ink or indelible pencil, and do not fold. Be sure to write the cause of death clearly and correct age is especially important. Physicians: please write

50893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50893

TN. 95639

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 6-22
(e) Length of stay in Baltimore (yrs., mos., or days) 21 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3602 Springdale Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander Webster

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Col

6 (a) Single, married, widowed, or divorced: Seperated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 11/1888

8. AGE: Years 59 | Months 0 | Days 4 | If less than one day ... hr. ... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Alec Webster (D
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Wilson (D
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (b) Date thereof 4/21/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Frederick Ave

18 (a) Funeral director Chas R. Law
(b) Address 802 Madison Ave

19 (a) APR 21 1947 (b) Huntington Williamson Md
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 15/1947 19 ... at 7.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 23/45 19 ... to Mar. 15 1947, and that I last saw h. im alive on Mar. 15 1947

Immediate cause of death	Duration
Bronchial pneumonia	
Due to	
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C Rowell Huffman M. D.
Address Balt. City Hosp Date signed 18 Mar. 47

PLEASE WRITE PLAINLY. Physicians: please write the cause of death in such terms that correct age is especially important.

VS 150

X

C50894 CIARA Sewell

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

Registered No. C50894

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 117 W Hamburg St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1637 Eager St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Sewell

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 12, 1930

8. AGE: Years 16 | Months 4 | Days 6 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Leo Sewell
13. Birthplace Va

MOTHER
14. Maiden Name Freddie Mae Wilson
15. Birthplace Balto Md

16 (a) Informant Venus Wilson (G-M)
(b) Address 117 W Hamburg St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/21/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto Co. Md

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 105 W Montgomery St

19 (a) [illegible] Washington Boulevard

APR 21 1947

PLEASE WRITE PLAINLY WITH UNFADING INK. Be sure the causes of death clearly and legibly. correct age is especially important. Physicians: please write the

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1947, at 10 30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/26 1946 to 4/18 1947 and that I last saw h alive on 19

Immediate cause of death	Duration
PULMONARY Tuberculosis	approx 1 yr
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature K. Howard M.D.

Address 15 W E. Madison St Date signed 4/19

RAYNER BROWNE X

G50895

OSING

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82

Registered No. G50895

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians; please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 43 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2404 Calverton Heights
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME John Robert Osing
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 21, 1889

8. AGE: Years	Months	Days	If less than one day
57	6	27	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Coal dealer
11. Industry or business Self

FATHER
12. Name John D. Osing
13. Birthplace Maryland (Balto.)

MOTHER
14. Maiden Name Mary Hamke
15. Birthplace New York

16 (a) Informant Mr. Frederick Osing
(b) Address 838 Whitmore Ave.

17 (a) Burial (b) Date thereof 4/21/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto., Md.
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.
19 (a) APR 21 1947 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1947, at 6:40 P.M
21. I certify that death occurred on the date above stated; that I attended deceased from April 6 1947, to April 18 1947, and that I last saw him alive on April 18 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Marked Emaciation	
Due to Cystitis	
Other Conditions Sciatic paraplegia (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Edward Burkhardt M.D. Address 1125a Druid Hill Ave. Date signed 4/18/47

VS 150

G50896

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G50896 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St
(c) Hospital or institution: South Balto. Gen. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2443 E. Preston St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Murray Hughes

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Auneita C. Hughes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1902

8. AGE: Years	Months	Days	If less than one day
44	11	9	hr. min.

9. Birthplace Wash, D.C. (Town, county, and state)
10. Usual Occupation self-employed
11. Industry or business Taveren Owner

FATHER
12. Name James Hughes
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Rose A Hughes
15. Birthplace Balto Md.

16 (a) Informant wife Mrs. Auneita Hughes
(b) Address 2443 E. Preston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/22/27 (month) (day) (year)
(c) Cemetery or crematory Wiseburg
Location Wiseburg Md.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves

19 (a) APR 21 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1947 at 3:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 16 1947 to April 19 1947 and that I last saw h[illegible] alive on April 19 1947.

Immediate cause of death	Duration
Subarachnoid Hemorrhage	
Due to Hypertensive Cardio-Vascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harold Dillon M. D.
Address 1213 Light St Date signed Apr 19, 47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Be sure that the causes of death clearly and logically correct age is especially important. Physicians: please write the c

VS 150

C50897

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C50897

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1204 Russell St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1204 Russell St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN A. STRODTMAN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWER

6 (b) Name of husband or wife CATHERINE STRODTMAN
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) NOV 2-1870

8. AGE: Years	Months	Days	If less than one day
76	5	17	hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)
10. Usual Occupation LABORER & CARPENTER.
11. Industry or business BALTO CITY.

FATHER
12. Name HENRY STRODTMAN
13. Birthplace NOT KNOWN

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace NOT KNOWN

16 (a) Informant WILLIAM T OWENS
(b) Address 1009 RUSSELL ST

17 (a) BURIAL (b) Date thereof APRIL-22-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location BALTO. MD.

18 (a) Funeral director Bernard C Harlr
(b) Address 131 E West St

19 (a) APR 21 1947 Huntington, Md.
(Date filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1947, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 17 1947 to Apr. 19 1947 and that I last saw h. alive on Apr. 19 1947.

Immediate cause of death	Duration
Myocarditis	24 hr
Due to Arteriosclerosis	4 yr
Due to Hypertension	4 yr
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature
Address 517 Alott St Date signed 4/19/47 M D

PLEASE WRITE PLAINLY, WITH INK. Be sure to write the causes of death clearly and legibly. Please write correct age is especially important. Physicians: please write

VS 150

G50898

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G50898 Registered No. 1702

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Falls Road
(c) Hospital or institution: D.A. Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.A.
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Frederick
(c) City or town Frederick (If outside city or town limits, write RURAL and give town)
(d) Street No. Y.M.C.A. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rene Cassard, Jr.

3 (b) If veteran, name war: W. War #II

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband or~~ wife: Eleanor Whittier Brown

6 (c) If alive, give age: 20 years

7. Birth date of deceased (mo., day, yr.): June 29, 1920

8. AGE: Years: 26 | Months: 9 | Days: 21 | If less than one day: ____ hr. ____ min.

9. Birthplace: Baltimore, Md. (Town, county and state)

10. Usual Occupation: Retail Cook

11. Industry or business: Markell & Hand Co.

FATHER
12. Name: Rene Cassard
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Antoinette Markell
15. Birthplace: Frederick, Md.

16 (a) Informant: Mr. Edwin Cassard (bro.)
(b) Address: Preston Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4/21/47 (month) (day) (year)
(c) Cemetery or crematory: U.S. Arlington National
Location: Arlington Va.

18 (a) Funeral director: Stewart Memorial Co.
(b) Address: 108 W. Monument Ave.

19 (a) Date received by registrar: APR 21 1947 Huntington Williams, M.D. Registrar

correct age is especially important. Information must be given.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4/19 1947, at 5:25 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy & Inq. thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Crushed Chest, Intra-cranial Hemorrhage

Due to:

Other Conditions: Lacerations of nose & forehead

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4/19/47 at 4:27 P.M.
(b) Where did injury occur? 4600 Blk Falls Road.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Auto struck Pole (driver)

23. Signature: Earl L. Royer M.D. Medical Examiner.
Date signed 4-19-47

G50899

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. G50899

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2234 Frederick Avenue
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Y
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2234 Frederick Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY SCHOLING (MARY A. SCHOLING)

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: D W Scholing
6 (c) If alive, give age
7. Birth date of deceased (mo., day, yr.): Dec 6 1846
8. AGE: Years 90 | Months 4 | Days 12 | If less than one day ... hr. ... min.
9. Birthplace: Balto Md (Town, county, and state)
10. Usual Occupation: none
11. Industry or business

FATHER
12. Name: John G Tellmann
13. Birthplace: Germany

MOTHER
14. Maiden Name: Elizabeth Twelsbeck
15. Birthplace: Germany

16 (a) Informant: Harry M Scholing (Son)
(b) Address: 2234 Frederick Ave. (Same)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-21-47 (month) (day) (year)
(c) Cemetery or crematory: Baltimore
Location: Baltimore

18 (a) Funeral director: Jos Jaenders Son
(b) Address: 1927 Park Ave.

19 APR 21 1947 Huntington Williams, Registrar
(Registered by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/18/47 19..., at 5:10 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? ... While at work? ...
(d) Means of injury

23. Signature John R Travis M.D.
Medical Examiner.
Date signed 4/19/47

X

correct age is especially important. Informant

VS 151

50900 INNERS

BALTIMORE CITY HEALTH DEPARTMENT

BC#B-42316 CERTIFICATE OF DEATH V 157E Registered 50900

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 Yeager St (If rural give location)
(e) Citizen of foreign country (Yes or No)
If yes, name country

3 (a) FULL NAME Harvey F Inners

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 21, 1946

8. AGE: Years 1 | Months 13 | Days 27 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland (town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Charles Inners.
13. Birthplace Maryland

MOTHER 14. Maiden Name Catherine Slembaker
15. Birthplace Maryland.

16 (a) Informant Catherine Inners
(b) Address 1400 Yeager St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apl 22/47 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Taylor Ave

18 (a) Funeral director Shemaker & Sonora
(b) Address 3615-17 Christopher Ave

19 (a) [illegible] (b) Huntington Williams M.D.
Registrar

APR 21 1947

correct age is especially important

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1947, at 12:05 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Pneumonia, Left Lung

Due to

Other Conditions Congenital heart disease
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J McGeehan M.D.
Medical Examiner.
Date signed April 20, 47

VS 151

G50901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G50901

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3621 Buena Vista Ave.
(c) Hospital or institution: 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3621 Buena Vista Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Thomas Spurrier

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-10-3516

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna Mary Spurrier
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26-1871

8. AGE: Years 75 | Months 3 | Days 21 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Store Room Clerk

11. Industry or business Bal. Mar Corporation

FATHER
12. Name William Spurrier
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Frizell
15. Birthplace Maryland

16 (a) Informant Mrs. Anna M. Spurrier
(b) Address 3621 Buena Vista Ave.

17 (a) Burial (b) Date thereof April 21-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 2431 Falls Road

19 (a) (Date rec'd by registrar) APR 21 1947 (b) Harrington Mill Bros., Inc.

V S 150

PLEASE WRITE PLAINLY, with pencil or pen. Physicians: please write the CAUSES OF DEATH in such terms that a correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17-1947, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 19 46 to April 17 19 47, and that I last saw h/m alive on April 17 19 47.

Immediate cause of death	Duration
Cardiac Decomp - Arteriosclerotic CVD	2
Due to Generalized Arteriosclerosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lawrence F. Kinnamon MD
Address 5711 Falls Rd Date signed 4-17-47
M. D.

X

50902

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G50902 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1029 Wood Heights Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1029 Wood Heights Avenue (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Eli Emory Sterner

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Susie M. Sterner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12-1870

8. AGE: Years 76 | Months 6 | Days 6 | If less than one day hr. min.

9. Birthplace Pennsylvania (Town, county and state)

10. Usual Occupation Produce Dealer

11. Industry or business

FATHER
12. Name Levi Sterner
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Lydia A. Bailey
15 Birthplace Pennsylvania

16 (a) Informant Mrs. Susie M. Sterner
(b) Address 1029 Wood Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 22-1947 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Co. Maryland

18 (a) Funeral director Durgee Funeral Home
(b) Address 3631 Falls Road

19 (a) APR 21 1947 (Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18- 1947, at 10-55 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 15 1947 to April 18 1947, and that I last saw him alive on April 17 1947.

Immediate cause of death	Duration
(a) Coronary Thrombosis	3 days
Due to (b) Coronary Artery Dis.	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward Passman, M.D.
Address 903 Fallsway Date signed 4-18-47

PLEASE WRITE PLAINLY. Items must be answered carefully and correct as far as possible. Physicians: please write the cause of death correct age is especially important.

V S 150

50903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133a

Register No. 50903

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: Church Home + Hosp. 67
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 68 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 410 N Linwood Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr Charles Smearman.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Gertrude Smearman.
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) July 27, 1878.

8. AGE: Years	Months	Days	If less than one day
67 68	8	24. 28	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Railroad Engineer
11. Industry or business Railroad Driver.

FATHER
12. Name Henry J. Dreaman.
13. Birthplace Baltimore

MOTHER
14. Maiden Name Barbara Trush.
15. Birthplace Baltimore.

16 (a) Informant Gertrude Smearman
(b) Address 410 N Linwood Ave.

17 (a) Burial (b) Date thereof 4-22-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 E. Wolfe St. (31)

19 (a) APR 21 1947 Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1947, at 11:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 13 1947, to April 19 1947, and that I last saw him alive on April 19, 1947.

Immediate cause of death	Duration
Uremia	?
Due to Pyelitis	2+ yrs.
Due to Cystitis	2+ yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Allen Moulton M. D.
Address Church Home + Hosp. Date signed 4/19/47

VS 150

X

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

50904

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33B

G50904 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2006 Fleet, St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2006 Fleet, St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN W CRAWFORD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Annie Geis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 15, 1867

8. AGE: Years	Months	Days	If less than one day
79	5	3	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15 Birthplace

16 (a) Informant John P.C. Crawford
(b) Address 702 Dean, St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-22-47 (month) (day) (year)
(c) Cemetery or crematory Mount Olivet
Location 2930 Frederick Ave.
18 (a) Funeral director Lilly & Zeiler, Inc.
(b) Address 403 S. Wolfe St
19 (a) Filed Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1947, at 11:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 14 1947, to April 18 1947, and that I last saw alive on April 18 1947.

Immediate cause of death	Duration
Cerebral Arteriosclerosis	5 yrs.
Influenza	4 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature M. D.
Address Date signed 4/21/47

PLEASE WRITE PLAINLY. Fill in all blanks. Be sure to state the causes of death clearly and correct age is especially important. Physicians: please write the

V S 150

G50905

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83B

Registered No. G50905

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 622 Wildwood Parkway
(c) Hospital or institution:
16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 622 Wildwood Parkway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sophia M. Cannon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Milton Cannon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 17, 1866

8. AGE: Years 81 | Months 3 | Days 2 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John A. G. Goetz
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. James M. Jeffers
(b) Address 622 Wildwood Parkway

17 (a) Entombment (b) Date thereof April 21/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Rd.

18 (a) Funeral director Harry E. Weitzke
(b) Address 4101 Edmondson Ave.

19 (a) APR 21 1947 (b) Huntington Williams, M.D.
(Date received) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1937 to April 9 1947
and that I last saw h[er] alive on 4-19-47 1947

Immediate cause of death	Duration
Cerebral Thrombosis	7 days
Due to Generalized Atherosclerosis	
Due to Advanced Age	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. Bloomstrauben M. D.
Address 574 S. Fulton Ave Date signed 4-22-47

PLEASE WRITE PLAINLY. Please write the causes of death literally and accurately. Be sure correct age is especially important. Physicians: please write

VS 150

G50906

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G50906

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2728 E. Baltimore St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2728 E. Baltimore (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jessica M. Kay.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John A. Kay.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5-1891

8. AGE: Years 56 | Months 1 | Days 13 | If less than one day hr. min.

9. Birthplace Bad Axe Michigan (Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name John Pangborn
13. Birthplace Canada

MOTHER 14. Maiden Name Marie Haley
15. Birthplace Canada

16 (a) Informant John A. Kay
(b) Address 2728 E. Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/23/47 (month) (day) (year)
(c) Cemetery or crematory
Location Bad Axe Michigan

18 (a) Funeral director John A. Noad
(b) Address 3100 E. Baltimore St

19 (a) APR 21 1947 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18- 1947, at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 14 1946 to April 18 1947, and that I last saw h.s.h. alive on April 17 1947.

Immediate cause of death

	Duration
Acute Cardiac Failure	
Due to Coronary Artery	
Due to Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. A. Flannigan M.D.
Address 3503 Fait Ave Date signed 4-19-47

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and give correct age is especially important.

V S 130

0907 Med Exam Rec

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 5/12

G50907
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 197 Oakley Village
(If rural give location)
(e) Citizen of foreign country? [illegible] (Yes or No)
If yes, name country

3 (a) FULL NAME Natalie Helene McCormick ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: James

6 (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr) 11-11-11

8. AGE: Years 35 | Months 5 | Days 8 | If less than one day: hr. min.

9. Birthplace: New York
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Joseph Dovi
13. Birthplace: Italy

MOTHER
14. Maiden Name: Angelina D'Angelo
15. Birthplace: Italy

16 (a) Informant: Records
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/23/47 (month) (day) (year)

(c) Cemetery or crematory: New Cathedral Cem
Location: Balt. Md.

18 (a) Funeral director: Joseph Farace Inc
(b) Address: 204 Fayette Street

19 APR 21 1947 (Registrar) (b) Huntington Williams M.D. (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1947, at 6:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 18 1947 to Apr 19 1947, and that I last saw her alive on April 19 1947.

Immediate cause of death: Tetanus — Duration: 2 days

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: 4-20-47 See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. L. Dubois M. D.
Address John Hopkins Hospital Date signed 4-20-47

PLEASE WRITE PLAINLY. Physicians: please write the correct age in especially important.

C. L. Dubois M.D. Dupheath ✓

0908

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G50908 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city limits, write RURAL and give town)
(d) Street No. 626 Thames (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Losach

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 70 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business No Record

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof APR. 23/47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location Baltimore

18 (a) Funeral director Fred W Ozazewski
(b) Address 930 Evans Ave

19 APR 21 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D.

correct age is especially important. Physicians: please write plainly.

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MEDICAL CERTIFICATION

20. DATE OF DEATH 4/19/47 19..., at 10:55 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature John L Davis M.D.
Medical Examiner.
Date signed 4/21/47

G50909

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G50909

PLEASE WRITE PLAINLY, with ink. Physicians: please write the causes of death clearly and in full. Be sure correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2210 East Chase St.
(c) Hospital or institution: 81

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2210 E. Chase St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Gill

3 (b) If veteran, name war

3 (c) Social Security Account No. 214 - 14 - 8543

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Margaret M. Gill

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 11, 1888

8. AGE: Years	Months	Days	If less than one day
59	2	8	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Produce Dealer

11. Industry or business Self

FATHER
12. Name George Gill
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Louise Sadler
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Nellie Butler
(b) Address 2204 E. Biddle Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/23/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) APR 21 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 19 1947, at 6.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1945 to Apr 19 1947 and that I last saw him alive on Apr 19 1947.

Immediate cause of death	Duration
Carcinoma Breast	18 Mos.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jacob Fuchs M.D.
Address 182 N. Wash st. Date signed 4/21/47

C50910

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

over C50910 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3468 ChildsCourt
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3468 Childs Court (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country no

3 (a) FULL NAME David John Williams

3 (b) If veteran, name war: no

3 (c) Social Security Account No. -

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Mary A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/25/1870

8. AGE: Years 76 | Months 10 | Days 25 | If less than one day ____ hr. ____ min.

9. Birthplace ~~Washington~~ SLATINGTON, Pa.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace unknown

16 (a) Informant Mr. Thomas R. Williams
(b) Address 3468 Childs Court

17 (a) Removal (b) Date thereof April 21
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory ~~Catasauqua, Pa.~~ CATASAUQUA
Location Pennsylvania

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 127 St. Paul Street

19 (c) APR 21 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1947, at ____ M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1946 to Apr 1947 and that I last saw h~~er~~ alive on Apr 11 1947

Immediate cause of death	Duration
Pulmonary embolism	
Due to hypertensive cardiovas. dis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature P. W. Keister, M.D.
Address 302 Catasauqua Ave Date signed Apr 21 47

P.W. Keister +

PLEASE WRITE PLAINLY, WITH UNFADING INK. Please write the causes of death clearly and legibly. correct age is especially important. Physicians: please write

VS 150

G50911

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G50911

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1730 Linden Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1730 Linden Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Neustadt

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Dr Charles Neustadt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years 53 | Months 6 | Days | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Harry Holzander
13. Birthplace Austria

MOTHER 14. Maiden Name Anna B.
15. Birthplace Austria

16 (a) Informant Dr Charles Neustadt
(b) Address 1730 Linden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-22-47 (month) (day) (year)
(c) Cemetery or crematory Holland Interbor
Location Balto Md

18 (a) Funeral director Jenk Lewis Sons
(b) Address 1429 E. Balto St

19 (a) APR 21 1947 (Date filed by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1947; at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 10 1946 to April 21 1947 and that I last saw him alive on April 21 1947

Immediate cause of death	Duration
(a) Arteriosclerosis	
(b) Cerebral hemorrhage	1 year
Due to	
Due to hypertension	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles S Neustadt M. D.
Address 1730 Linden Ave Date signed 4/21/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Cross out words not correct; write the causes of death clearly and legibly. Physicians; please write the correct age is especially important.

VS 150

X

G50912

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G50912 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 615 George St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 615 George St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Garman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-25-1879

8. AGE: Years 67 | Months 5 | Days 24 | If less than one day hr. min.

9. Birthplace Calvert Co. Md (Town, county and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Joseph Germain
(b) Address 506 Pine St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 21 47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location A. A. County Md

18 (a) Funeral director Williams & Jackson
(b) Address 916 Penna ave

19 (a) Filed by registrar [illegible] for Williams MD Registrar

4 21 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1947, at 3. P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/4 1947 to 4/18 1947.
and that I last saw h[illegible] alive on April 18 1947.
Immediate cause of death Cerebral Hemorrhage
Due to Acute Dilation
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
7yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 4/19 1947

PLEASE WRITE PLAINLY, with ink or indelible pencil. Fill in the causes of death clearly and legibly. Correct age is especially important. Physicians: please write this certificate.

G50913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Off # 28392 / 181

G50913
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or Institution: Johns Hopkin 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1011 Somerset St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Perkins

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17, 1945

8. AGE: Years 1 | Months 9 | Days 1 | If less than one day ____ hr. ____ min.

9. Birthplace Balto., Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name James Perkin
13. Birthplace S.C

MOTHER
14. Maiden Name Callie Perkins
15. Birthplace S. C.

16 (a) Informant James Perkins
(b) Address 1011 Somerset St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/21/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location B. A. County, Md.

18 (a) Funeral director Joseph B. Locke, Jr.
(b) Address 1304 N. Central Ave

19 (a) Date received by registrar APR 21 1947 (b) Registrar Huntington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/18/1947, at 9:35 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy + Insp. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH 2nd 3rd degree burns of 75% of body.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-18-47 at 9 P.M.
(b) Where did injury occur? 1011 Somerset St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Mattress Ignited cigarette fire

23. Signature [signature] M.D.
Medical Examiner.
Date signed 4-19-47

correct age is especially important. Physicians: please write

G50914 — BALTIMORE CITY HEALTH DEPARTMENT — G50914

CERTIFICATE OF DEATH

Matthew 131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore 1704 N. Wolfe St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 76 years.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1704 N. Wolfe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John L. Matthew

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	widowed

6 (b) Name of husband or wife –
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25 - 1869

8. AGE: Years	Months	Days	If less than one day
77	4 3	24	hr. min.

9. Birthplace Austria (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name John L. Matthew
13. Birthplace Austria

MOTHER
14. Maiden Name Barbara ?
15. Birthplace Austria

16 (a) Informant Mrs. Elizabeth Epping
(b) Address 2223 Chesterfield Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/22/47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave

18 (a) Funeral director John H Connelly
(b) Address 418 Eastern Ave. Essex Md.

(Date received by registrar) APR 21 1947 (b) Registrar Huntington Williams M.D.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use no abbreviations except age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1947, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 4 1947 to April 18 19, and that I last saw h.i.m. alive on April 17 1947.

Immediate cause of death	Duration
Acute Cardiac Failure.	
Due to Cardio-Vascular Renal	
Due to Disease.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. A. Flanigan M.D.
Address 3503 Fait ave. Date signed 4-19-47

X

50915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

104

Registered No. G50915

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 808 N Carrollton ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore 25 (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 808 N Carrollton ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Silas J. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-18-4756

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Louise Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 25 1894

8. AGE: Years 52 | Months 7 | Days 24 | If less than one day hr. min.

9. Birthplace Matthews County Va (Town, county, and state)

10. Usual Occupation Plasterer

11. Industry or business

FATHER
12. Name William H. Smith
13. Birthplace Matthews County Va

MOTHER
14. Maiden Name Hannah Jaris
15. Birthplace Matthews County Va

16 (a) Informant 808 N. Carrollton ave
(b) Address Mrs Louise Smith

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 23 1947 (month) (day) (year)
(c) Cemetery or crematory Western Star Cemetery
Location Baltimore County Md

18 (a) Funeral director Joseph A. Lewis
(b) Address 6 Hyatt Bane St

19 (d) APR 21 1947 (Date rec'd by registrar) Huntingtown Williams, M.D.

MEDICAL CERTIFICATION 30

20. DATE OF DEATH April 19 1947, at 12 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/18 1947 to 4/19 1947.
and that I last saw her alive on 4/19/1947
Immediate cause of death

	Duration
R C Colon	
Due to Pneumonia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Goldstone M. D.
Address 1131 Harlem Ave (Date signed) 4/19/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Be sure the correct age is especially important.

VS 150

G50916

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered G50916

PLEASE WRITE PLAINLY, with UNFADING INK. Use no abbreviations. Do not write the causes of death clearly and legibly. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 918 W. Baltimore St.
(c) Hospital or institution: 18
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 918 W Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice V Cronise

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Charles S

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4th 1865

8. AGE: Years 81 | Months 9 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation House Work

11. Industry or business at home

FATHER 12. Name George Linton

13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Elizabeth Goodman

15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Stanley M. Cronise

(b) Address 764 McHenry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/22/47 (month) (day) (year)

(c) Cemetery or crematory London Park Cem.

Location

18 (a) Funeral director John J. Conway & Son

(b) Address 901-03 Hollins St.

19 (a) APR 21 1947 (Date rec'd by registrar) Huntington, Wilson, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19th 1947, at 2 30A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1944 to 4-19-1947 and that I last saw h[illegible] alive on 4-18-1947

Immediate cause of death Arteriosclerotic myocarditis — Duration ?

Due to Generalized arteriosclerosis

Due to Advanced age

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. B. Schreiber M. D.

Address 54 S. Fulton Ave Date signed 4-19-47

VS 150

50917

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30

Registered No. C50917

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore 13
(If outside city or town limits, write RURAL and give town)
(d) Street No. 842 W. Franklin St. (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME VIRGIL DAVIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Mary Davis.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 24, 1896

8. AGE: Years	Months	Days	If less than one day
50 48	3 4	24	.....hr. .....min.

9. Birthplace..... (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John Davis
13. Birthplace Alabama

MOTHER
14. Maiden Name Mary
15. Birthplace Alabama

16 (a) Informant Mrs. Raymond Davis
(b) Address 603 George St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-21-1947. (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location.....

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St.

19 APR 21 1947 (Date rec'd by local reg.) (b) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17, 1947 at 6.45 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis
Syphilitic aortitis

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature George G. Merrill M.D.
Medical Examiner.

Date signed 4/18/47

PLEASE WRITE VERY CLEARLY. Physicians: please write correct age is especially important.

VS 151

G50918

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G50918 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 906 Argyle Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 906 Argyle Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nathaniel Adams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Carrie Adams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 2, 1887

8. AGE: Years 59 | Months 4 | Days 15 | If less than one day hr. min.

9. Birthplace Matthews Co. Virginia (Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER
12. Name Nathaniel Adams.
13. Birthplace Matthews Co. Virginia

MOTHER
14. Maiden Name Ellen Clark
15. Birthplace Matthews Co. Virginia

16 (a) Informant Mrs. Carrie Adams.
(b) Address 906 Argyle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-21-1947. (month) (day) (year)
(c) Cemetery or crematory North Station
Location Matthews County, Va.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N Schroeder St.

19 (a) APR 21 1947 (Date rec'd by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1947, at 9:35 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Renal disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Gilfert M.D. Medical Examiner.
Date signed April 18, 1947

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly; correct age is especially important.

VS 151

G50919

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G50919

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 426 Burgundy St. (If rural, give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Emma Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F E Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife James Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
52			....hr. ....min.

9. Birthplace Danville Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Stewart Hemlling
13. Birthplace Va

MOTHER
14. Maiden Name Nelle ?
15. Birthplace Danville Va.

16 (a) Informant Betty Hawks
(b) Address 1225 Fairmount Ave. Phila.

17 (a).....(Burial, cremation, or removal) (b) Date thereof 4/22/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary 4 22 47
Location Baltimore

18 (a) Funeral director Walter B. Gruger
(b) Address 1 W Hamilton St.

19 (a) APR 21 1947 (Date rec'd by registrar) (b) Huntingdon Pennsylvania

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1947, at 11 30 AM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH.....
Myocardial degeneration

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature Earl L Gruger M.D. Medical Examiner
Date signed 4-21-47

Please correct age is especially important. Physicians: please write legibly.

VS 181

G50920

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered G50920

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1257 E. North Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1257 E. North Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAMIE AGNES SPRING

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Harry L. Spring
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 20, 1887

8. AGE: Years	Months	Days	If less than one day
60	1	28	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John J. Garvey
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Murray
15. Birthplace Ireland

16 (a) Informant Miss Margaret Spring
(b) Address 1257 E. North Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/22/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 APR 21 1947 (b) Huntington Williams, M.D. Registrar
Registered by

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1947, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 16 1947 to April 18 1947, and that I last saw her alive on April 17 1947.

Immediate cause of death	Duration
Chronic Hypertension	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Edward B. Wolfe
Address 1331 E. North Ave Date signed 4-18-47 M. D.

PLEASE WRITE PLAINLY. Ink or pencil. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

VS 150

G50921

GM. 109900

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

Registered No. G50921

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Balto. City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4Days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 409 S. Clinton St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Davis, George (GEORGE W. DAVIS)

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Nora W. Davis

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) March 4-1883

8. AGE: Years	Months	Days	If less than one day
64	1	15	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business Daniel Millers

FATHER

12. Name George Davis

13. Birthplace Md.

MOTHER

14. Maiden Name NicsyAnn Bryant

15. Birthplace N.C.

16 (a) Informant Records Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/22/47 (month) (day) (year)

(c) Cemetery or crematory Good Shepard cemetery

Location Ellicott City, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.

(b) Address NORTH AVE. & BROADWAY

19 (a) APR 21 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1947, at 9.05p M

21. I certify that death occurred on the date above stated; that I attended deceased from April 15 1947 to April 19 1947, and that I last saw h im alive on April 19 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Tumor of left chest	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Biopsy on 4-18-47

Major findings of operation Report not back

of autopsy —

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature W. Doyle Waldron M. D.

Address B.C.H. Date signed 4-19-47

PHYSICIAN

Underline the cause to which death should be charged statistically.

over

PLEASE WRITE PLAINLY, WITH UNFADING INK. Fill in all items. Give the causes of death clearly and legibly. Be correct age is especially important. Physicians: please write the cause of death in item 21.

VS 150

X

G50922

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered No. G50922

PLEASE WRITE PLAINLY, with unfading ink. Give the causes of death clearly and legibly. Use only standard abbreviations. Do not use ditto marks. Be sure that the correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3026 Dillon Street
(c) Hospital or institution: No
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3026 Dillon Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN BARRETT SMITH

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 220-22-4572

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lula A. Smith

6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Dec. 27, 1892

8. AGE: Years 54 | Months 3 | Days 24 | If less than one day ... hr. ... min.

9. Birthplace Delaware (Town, county, and state)

10. Usual Occupation Plumber

11. Industry or business

FATHER
12. Name Frank Smith
13. Birthplace Delaware

MOTHER
14. Maiden Name Susen Cooper
15. Birthplace Delaware

16 (a) Informant Mrs. Lula A. Smith
(b) Address 3026 Dillon Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/23/47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY

19 (a) APR 21 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION PM

20. DATE OF DEATH April 20, 1947, 3.35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 11 1946, to Apr. 20 1947 and that I last saw him alive on Apr. 20 1947.

Immediate cause of death	Duration
Cancer of the Uri-	
Due to nary Bladder	6 m.
Due to	
Due to	
Other Conditions Metastasis to the Lungs (Include pregnancy within 3 months of death)	Unknown

Date of operation
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. A. Rosenblatt M. D.
Address 3018 O'Donnell St. Date signed 4-21-47

VS 150

G50923

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G50923

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 633 N. Spring St. (If rural give location)
(e) Citizen of foreign country? N (Yes or No)
If yes, name country.....

3 (a) FULL NAME Rebecca Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 65 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Sharon Hill Pa (Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER
12. Name Reuben Banks
13. Birthplace Sharon Hill Pa

MOTHER
14. Maiden Name Nellie Banks
15. Birthplace Sharon Hill Pa

16 (a) Informant Preston Tuck
(b) Address 625 N. Spring St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 22, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location Brooklyn Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1510 Orleans St

19 APR 21 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1947, at 3 P M

21. I certify that I took charge of the remains described above, held an Insp. & Inquest (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at ..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Emil Reyer M.D. (Medical Examiner.)
Date signed 4-18-47

X

G50924

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G50924

PLEASE WRITE PLAINLY, WITH UNFADING INK. Fill in the causes of death clearly and legibly. Give correct age in years, months, days, hours or minutes. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1506 Orleans St.
(c) Hospital or institution: 6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1506 Orleans St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Jones

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Widowed

6 (b) Name of husband or wife Mary Jones
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5, 1873

8. AGE: Years	Months	Days	If less than one day
69	1	11	hr. min.

9. Birthplace Chase Md. (Town, county, and state)
10. Usual Occupation Handy Man
11. Industry or business

FATHER
12. Name John Jones
13. Birthplace Md.

MOTHER
14. Maiden Name Louise Hill
15. Birthplace Md.

16 (a) Informant Bell Jones
(b) Address Salisbury, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/21/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantly Ave.

19 (a) APR 21 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION 4/16/47 2:30 P.M.

20. DATE OF DEATH 4/16/47 19 , at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/25 1947 to 4/16 1947 and that I last saw h.r alive on 4/16 1947

Immediate cause of death	Duration
Coronary occlusion	
Due to arterio-sclerotic	
Due to heart disease	VNK
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M.D.
Address 1500 E. Madison St. Date signed 4/19

Rayner Brown M.D.

G50925 BGH

5 12235 G18997

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1579

Register No. G50925

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 406 Chapel St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard Tillman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-15-45

8. AGE: Years	Months	Days	If less than one day
2	-2	-2	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Smith Croyland
13. Birthplace Va.

MOTHER
14. Maiden Name Marion Tillman
15. Birthplace Va.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 22, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cem.
Location Brooklyn, Md.

18 (a) Funeral director Elroy B. Wilson
(b) Address 1000 Baltimore ave

19 (a) APR 21 1947 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1947 at 5:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 24 1947 to Apr 17 1947 and that I last saw him alive on April 17 1947.

Immediate cause of death Aspiration of vomitus — Duration Terminal

Due to Post-operative ileus

Due to Colectomy, Megacolon

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 4/14/47

Major findings of operation: Megacolon

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry E. Bahrenburg M.D.
Address Johns Hopkins Hospital Date signed 4/17/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

VS 150

X

G50926

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G50926

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use typewriter if possible. Spell out full the name of the cause of death clearly and legibly. Give the exact cause of death, not the mode of dying, such as heart failure, asthenia, etc. If from violence, state the nature of injury, and whether accidental, suicidal, or homicidal. If a woman, whether single, married, widowed, or divorced, and the date of birth, and if married, widowed, or divorced, the name of husband or wife. The certificate must be filled out, signed, and delivered to the undertaker before the body is removed. Physicians: please write the cause of death clearly and legibly. Omission to answer any question will cause delay. Please answer all questions. Be sure that the age is correct, age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette and Calhoun
(c) Hospital or institution: Franklin Square Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 37 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 7
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2930 Eutaw Pl.
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank C. Linthicum

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Louise Linthicum

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 8, 1866

8. AGE: Years 81 | Months 5 | Days 12 | If less than one day hr. min. 42

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Wm Charles G. Linthicum
13. Birthplace Maryland

MOTHER
14. Maiden Name Louise Linthicum
15. Birthplace Maryland

16 (a) Informant Louise Linthicum
(b) Address 2950 Eutaw St. Balt.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 22/47 (month) (day) (year)

(c) Cemetery or crematory Greenmount
Location Greenmount Ave & Oliver Sts

18 (a) Funeral director John O. Mitchell Home
(b) Address 1900 Eutaw Place
(c) Registered Apr 21 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-20 1947, at 3 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-14 1947 to 4-20 1947, and that I last saw him alive on 4-20 1947.

	Duration
Immediate cause of death: Uremia	14 days
Due to: Chronic benign prostatic hypertrophy	6 mos. (?)
Due to:	
Other Conditions: Arteriosclerotic heart disease (Include pregnancy within 3 months of death)	?

Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stanley B. Klyanowicz M. D.
Address Franklin Sq. Hosp. Date signed 4-20-47

137a

VS 150

G50927 Rustejko ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G50927

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6723 Graceland ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6723 Graceland ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Anthony Rose (Rustejka)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Lena Rose (Rustejka)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 76 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER 12. Name unknown
13. Birthplace Poland

MOTHER 14. Maiden Name unknown
15. Birthplace Poland

16 (a) Informant Andrew Rose Rustejka
(b) Address 6723 Greceland ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 - 22 - 47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 409 S. Chester Street

19 (a) APR 21 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION 1150

20. DATE OF DEATH April 18 1947, at A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 7 1947 to April 18 1947 that I last saw him alive on April 18 1947

Immediate cause of death Hypostatic Pneumonia
Due to Chronic cardiovascular renal disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: 72 hrs. / 6 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George D. Lyford M. D.
Address 433 N. Potomac St. Date signed 4/18/47

X

G50928

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

128

Registered No. G50928

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: UNIV HOSPITAL 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 14

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2912 Reuckert Avenue (If rural give location)
(e) Citizen of foreign country? None (Yes or No)
If yes, name country

3 (a) FULL NAME FREDRICK L. LIEDTKE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Lillian Liedtke
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 19, 1906

8. AGE: Years	Months	Days	If less than one day
40	8	1	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Work Manager
11. Industry or business Md. Dry Dock Co.

FATHER
12. Name Otto Liedtke
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Schorr
15. Birthplace Md.

16 (a) Informant Mrs. Lillian Liedtke
(b) Address 2912 Reuckert Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/23/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road 14

19 (a) APR 21 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 APRIL 1947, at 2.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6 APRIL 1947 to 20 APRIL 1947, and that I last saw him alive on 20 APRIL 1947.

Immediate cause of death	Duration
PERITONITIS	
RENAL FAILURE	
Due to: HEMORRHAGIC PANCREATITIS	
Due to:	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 14 APRIL 47
Major findings of operation: CHOLECYSTITIS & PANCREATITIS
of autopsy: PERITONITIS, PANCREATITIS

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert E. Bauer M. D.
Address Univ. Hospital Date signed 20 April 47

VS 150

X

Dr. Janney
7101 Harford Road

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

Registered No. G50929

PLEASE WRITE PLAINLY, WITH UNFADING INK. Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3006 Christopher Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3006 Christopher Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles J. Endres

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Eva Endres
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 14, 1865

8. AGE: Years	Months	Days	If less than one day
82	3	4	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Eva Endres
(b) Address 3006 Christopher Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/22/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5605 Harford Road

APR 21 1947

19 (a) (Date rec'd by registrar) (b) Huntington Williams, Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946, to Apr. 18 1947, and that I last saw h[illegible] alive on Apr. 18, 1947

Immediate cause of death	Duration
Coronary Heart Disease	?
Due to Arteriosclerosis	
Bilateral Inguinal Hernia	
Due to Arthritis, Spina	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan Janney M. D.
Address 7101 Harford Rd. Date signed 4/21/47

G50930

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G50930

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use typewriter if possible. Do not abbreviate or use ditto marks. Be sure to write the causes of death clearly and legibly. Give full name of deceased. If not in hospital or institution, give residence instead of hospital or institution. Write out age if less than one day. If unknown, or if deceased was a stillborn child, say so. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Avenues
(c) Hospital or institution: St. Agnes Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3107 Gerena Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carolina Kratzer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single, married~~, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Adam J. Kratzer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29, 1874

8. AGE: Years: 72 | Months: 9 | Days: 25 | If less than one day: 23 hr. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual Occupation: Housewife.

11. Industry or business

FATHER
12. Name: Andrew Dittman
13. Birthplace: Md.

MOTHER
14. Maiden Name: Juliana —
15. Birthplace: Md.

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof 4/23/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Balto

18 (a) Funeral director: L. J. Rusch.
(b) Address

19 (a) (b) Huntingtown, Williamsport, Md.
(Date received by Registrar) (Registrar's address)

APR 21 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/20 1947, at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12:30 4/20 1947 to 3:30 4/20 1947 and that I last saw h[illegible] alive on 4/20 1947.

Immediate cause of death	Duration
Coronary Occlusion	
Due to Cardiac Failure	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Milton Smith, Jr. M. D.
Address St. Agnes Hosp. Date signed 4/22/47

X

0931 — Square # 4 — BALTIMORE CITY HEALTH DEPARTMENT — #4 — G50931 Registered No.

CERTIFICATE OF DEATH 183

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Eliot Street
(c) Hospital or institution: City Morgue 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
FOUND:
(a) State (b) County
(c) City or town Pier 1, Md. Drydock, Fairfield, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Unknown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1907

8. AGE:	Years	Months	Days	If less than one day
about 40 ?				hr. min.

9. Birthplace Unknown (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant "
(b) Address "

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY APR 14 1947

18 (a) Funeral director Commissioner of Health
(b) Address

APR 21 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3, 1947, at 9 20 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 25/6
(a) Date of injury 4/3/47 at about 7 45a M.
(b) Where did injury occur? Pier #1 - Fairfield, Md
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? ?
(d) Means of injury Found drowned

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed Apr. 3, 1947

VS 151

X

Physicians: please write the correct age. It is especially important.

G50932

BALTIMORE CITY HEALTH DEPARTMENT ✓

CERTIFICATE OF DEATH 94a

G50932
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use typewriter if possible. Do not write the causes of death clearly and legibly. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland ✓
(b) Street address 2101 Old Spring Lane
(c) ~~Hospital or~~ institution:
Old Spring Nursing Home ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 W. Old Spring Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie T. Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married, widowed, or divorced~~
Female	White	Widowed

6 (b) Name of husband or wife William A. Taylor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8th 1865

8. AGE: Years	Months	Days	If less than one day
81	10	9	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Home

11. Industry or business —

FATHER
12. Name George S. Gilmeyer
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth McGuire
15. Birthplace Md.

16 (a) Informant Mrs. Grace Stalfort
(b) Address 607 N. Payson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/22/47 (month) (day) (year)
(c) Cemetery or crematory Natural
Location Baltimore Md

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

APR 21 1947 (Date filed by registrar) (Huntington Williams) M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17th 1947, at 5 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1 1946, to April 17 1947 and that I last saw he alive on April 17 1947.

Immediate cause of death	Duration
Coronary Thrombosis	2 days
Due to Generalized Arteriosclerosis	15 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify one of place)
(e) Means of injury

23. Signature Herman K Klemm M. D.
Address 3803 Edmondson Ave Date signed 4/15/47

G50933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G50933 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Fill in all blanks. Give the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2112 Kentuckey Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2112 Kentuckey Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie C. Conner

3 (b) If veteran, name war: W
3 (c) Social Security Account No. NIAE

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Charles H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10 1870

8. AGE: Years 76 | Months 5 | Days 9 | If less than one day ..... hr. ..... min.

9. Birthplace Centerville Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown Barrett
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Floyd
15. Birthplace Maryland

16 (a) Informant Charles M. Conner
(b) Address 2112 Kentuckey Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/22/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) ..... (Date mailed by registrar) (b) Huntington Williams, M.D. Registrar

APR 21 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1947, at 11:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/x 1947, to 4/19 1947, and that I last saw h[illegible] alive on 4/19 1947.

Immediate cause of death: Coronary Thrombosis — Duration:
Due to: Hypertension Cardiovascular disease
Due to:
Other Conditions: Chronic phlebitis Syph Contrib Cy
Pulmonary Infarction
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature W. N. Townshend Jr. M. D.
Address 14 E. Eager St. Date signed 4/21/47

X

George E. Wells
4100 Edmondson Ave.

G50934

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G50934

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2300 W. Lanvale St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2300 W. Lanvale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Oda Belle Talbot Hilton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frederick Hilton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 14, 1882

8. AGE: Years 65 | Months 3 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name of FATHER: Benjamin Talbot

13. Birthplace of FATHER: Maryland

14. Maiden Name of MOTHER: Sarah Martin

15. Birthplace of MOTHER: Maryland

16 (a) Informant Frederick Hilton

(b) Address 2300 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-2-47 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Baltimore Md

18 (a) Funeral director Wm. Cook Inc.

(b) Address 1217 St. Paul St.

19 (a) 1947 (Date received by registrar) (b) Registrar Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1947, at 9:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 8, 1947 to April 19 1947, and that I last saw h.e.r. alive on April 18, 1947.

Immediate cause of death	Duration
Edema of lungs	1 day
Due to Apoplexy	11 days
Due to Hypertension	3 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. E. Wells M. D.

Address 4100 Edmondson Ave Date signed 4/19/47

X

C50935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 50

Registered No. C50935

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2444 Frederick Ave.
(c) Hospital or institution: ..... No

(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2444 Frederick Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3 (a) FULL NAME Wilhelmina Marguerite Lauer

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Lee F. Lauer
6 (c) If alive, give age: 65 Years

7. Birth date of deceased (mo., day, yr.): August 12, 1901

8. AGE: Years: 45 | Months: 8 | Days: 7 | If less than one day: ..... hr. ..... min.

9. Birthplace: Baltimore Maryland (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business: Home

FATHER
12. Name: August A. Krueger
13. Birthplace: Germany

MOTHER
14. Maiden Name: Margaret Bayer
15. Birthplace: Germany

16 (a) Informant: Lee F. Lauer
(b) Address: 2444 Frederick Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-22-47 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore Maryland

18 (a) Funeral director: George L. Shryock
(b) Address: 2101 Frederick Ave.

19 (a) APR 22 1947 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19, 1947, at 7:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 14 1946, to Apr 19 1947, and that I last saw h[illegible] alive on April 18 1947.

Immediate cause of death: Uremia Coma nomatosa — Duration: 9 Mo
Due to: .....
Due to: .....
Other Conditions: .....
(Include pregnancy within 3 months of death)
Date of operation: .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature: Samuel Katzenberg M.D.
Address: 924 Medical Arts Date signed: 4/24/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Be sure that the information given is correct. Age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G50936

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

G50936 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be answered. Do not use ditto marks. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1911 E 32nd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Irene Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife C. Mills Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/20/1898

8. AGE: Years 48 Months 8 Days If less than one day hr. min.

9. Birthplace Balto. / Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Charles McShane
13. Birthplace Balto

MOTHER
14. Maiden Name Catherine Glenn
15. Birthplace Balto

16 (a) Informant C. Mills Johnson
(b) Address 1911 E. 32nd Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 23-47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Road

18 (a) Funeral director Chas. F. Evans & Son Inc
(b) 1 W. Mt Royal Ave

19 (a) APR 22 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/20 1947 at 12 05 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/14 1947 to 4/20 1947 and that I last saw h[illegible] alive on 4/20 1947

Immediate cause of death Respiratory failure — Duration

Due to Cerebro-vascular accident

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ward W. Mills Jr. M.D.
Address Mercy Date signed 4/20/47

VS 150

G50937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 9213

Registered No. G50937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item to be answered. Where there is no entry write "None." Be sure to write the cause of death clearly and legibly. Physicians: please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3041 Abell avenue
(c) Hospital or institution: 12

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3041 Abell avenue
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME LUCY M. DAUGHERTY

3 (b) If veteran, name war --
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Edward A. Daugherty
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21, 1862

8. AGE: Years 84 | Months 9 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER: 12. Name George W. Reay
13. Birthplace England

MOTHER: 14. Maiden Name Josephine Deady
15. Birthplace Maryland

16 (a) Informant Edward A. Daugherty
(b) Address 3041 Abell avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/22/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. J. Cogan's Son Inc
(b) Address 118 N. Mt. Royal Ave

APR 22 1947 (Date rec'd) (b) Huntington Williams MD (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 7 1945, to April 19 1947, and that I last saw her alive on April 18 1947

Immediate cause of death	Duration
Chronic Mitral Regurgitation	1 Yr
Due to Arterial Hypertension	2 Yrs.
Due to Arterial Sclerosis	2 Yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H B Wheatley MD M.D.
Address 1279 Fulton Ave Date signed 4/19/47

VS 150

C50938

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 100 B

Registered No. C50938

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 102 Race Street.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME MARY . GREEN

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Alexander
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 2-13-1901

8. AGE: Years	Months	Days	If less than one day
46	2	7	.....hr. .....min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name W W Edwards
13. Birthplace Md

MOTHER
14. Maiden Name Annie Brooks
15. Birthplace Md

16 (a) Informant William Green
(b) Address 34 W. Cross St.

17 (a) Burial (b) Date thereof 4 23 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Dorothy Cemetery
Location A. A. County, Md.

18 (a) Funeral director William Jackson
(b) Address 916 Penna ave

19 APR 22 1947 Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20, 1947 at 10.35 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Pulmonary Embolism

Due to Thrombophlebitis
Iliac veins.

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature Earl L Royer M.D.
Medical Examiner.
Date signed 3-21-47

VS 181

PLEASE WRITE PLAINLY, with ink or indelible pencil, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50939

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G50939 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered or "unknown" written where it does not apply. Write the causes of death clearly and legibly. Give correct age in years, months, days. If less than one day, hours or minutes. Physicians: please write the causes of death clearly and legibly. Physicians; please write the causes of death clearly and legibly. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1355 N. Calhoun St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME James Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Lenora

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-9-88

8. AGE: Years	Months	Days	If less than one day
58	7	10	..... hr. ..... min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER 12. Name Washington Johnson
13. Birthplace Md

MOTHER 14. Maiden Name Ellen Jackson
15. Birthplace Va

16 (a) Informant Mrs. Lenora Johnson
(b) Address 1355 N. Calhoun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/22/1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore, Md.

18 (a) Funeral director Wm. George & Sons
(b) Address 631 Druid Hill Ave.

19 (a) Date received by registrar APR 22 1947 (b) Registrar Washington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1947, at 11:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 18 1947, to April 19 1947, and that I last saw him alive on April 19 1947.

Immediate cause of death	Duration
Resp. Failure	
Due to Shock	
Due to Pneumonia - Lobar	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....(Specify type of place)
(e) Means of injury.....

23. Signature M. Gusack M. D.
Address 4th Date signed 4-19-47

X

50940

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122 B

Registered No. G50940

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Do not use abbreviations. Give the causes of death clearly and legibly. Physicians: please write the cause of death in plain terms. Do not use abbreviations. Give the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert Sts.
(c) Hospital or institution: Union Memorial Hosp. 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2742 St. Paul St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES F. WALLACE

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) Name of husband or wife ?
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 25, 1866

8. AGE: Years	Months	Days	If less than one day
80	11	27 26	— hr. — min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Farming
11. Industry or business

FATHER
12. Name James Wallace
13. Birthplace Maryland

MOTHER
14. Maiden Name Martha Timons
15. Birthplace Maryland

16 (a) Informant Hospital record
(b) Address 33rd + Calvert Sts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 24/47 (month) (day) (year)
(c) Cemetery or crematory Cumbridge Cem.
Location Lynde

18 (a) Funeral director John O. Mitchell & Son
(b) Address 1900 Eutaw Place

APR 22 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 2 1947 to Apr 21 1947, and that I last saw him alive on April 21 1947.

Immediate cause of death	Duration
Peritonitis	
Due to Volvulus	
Due to	
Other Conditions Arteriosclerotic heart dis	

(Include pregnancy within 3 months of death)

Date of operation April 3, 1947
Major findings of operation: Volvulus of sigmoid
Of autopsy Peritonitis, anasarca

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Wm. D. Tanner M. D.
Address Union Memorial Hosp. Date signed 4-22-47

VS 150

G50941

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √117a

G50941 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr 25 min
(e) Length of stay in Baltimore (yrs., mos., or days) 70

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1050 Bare St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Cassie M. Brown

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife: Chas. O. Brown
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Sept 24, 1876

8. AGE: Years	Months	Days	If less than one day
70	6	26 25	hr. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual Occupation: Housewife.
11. Industry or business

FATHER
12. Name: Horace Gould
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Sophie Pelling
15. Birthplace: Maryland.

16 (a) Informant: Husband
(b) Address: same

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4/23/47 (month) (day) (year)
(c) Cemetery or crematory MORELAND MEMORIAL
Location Taylor Ave. Balto Co. MD.

18 (a) Funeral director: Geo. W. Little
(b) Address: 2700 Edmondson Ave.

19 (a) APR 22 1947 (Filed by Registrar) Huntington Williams, M.D.

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1947, at 12 45 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute generalized peritonitis
Perforation of gastric ulcer

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L. Rogers M.D.
Medical Examiner.
Date signed 4-21-47

VS 181

50942

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30D

G50942
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Calvert St
(c) Hospital or institution:
Mercy Hospital 5'
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 33

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1224 E. Balto St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Silverman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Fannie Silverman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Samuel Silverman
13. Birthplace Poland

MOTHER
14. Maiden Name Rachael -
15. Birthplace Poland

16 (a) Informant Mr. Rubin Silverman
(b) Address 2007 E. Fairmount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-22-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Israel Cem.
Location Pulaski Ave

18 (a) Funeral director Jos. Levin Inc
(b) Address 1429 E. Balto St

APR 22 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1947 at 3:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1939 19 to April 21 1947.
and that I last saw him alive on April 21 1947.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Hypertension Cardio-Vascular Dis.	
Due to Arterio-sclerosis	
Other Conditions Diverticulum of Ileum	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mars A. Dru M. D.
Address 118 Biscuit St Date signed 4/22/47

903

VS 150

G50943

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No. G50943

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2627 Eastern Avenue
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2627 Eastern Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Joseph Krager M.D.

3 (b) If veteran, name war
3 (c) Social Security Account No. — — —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Theophilia
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) April 2, 1895

8. AGE: Years	Months	Days	If less than one day
52	—	19	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Physician
11. Industry or business

FATHER
12. Name Vincent Krager
13. Birthplace Poland

MOTHER
14. Maiden Name Malvina ?
15. Birthplace Poland

16 (a) Informant Mrs. Theophilia Krager
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-24-47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore
18 (a) Funeral director George A. Welsh
(b) Address 715 S. Ann Street

APR 22 1947 (b) Registered (Registrar) Functington Williams M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1947, at 9 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from October 1945 to April 21 1947, and that I last saw h[illegible] alive on April 9 1947.

Immediate cause of death Coronary Thrombosis — Duration 4/21/47
Due to —
Due to —
Other Conditions Cardiac enlargement — 1945
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lawrence A. Lenn M.D.
Address 11 E. Chase St Date signed 4/21/47

50944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

148 B

Registered No. G50944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be answered. Physicians: please correct age is especially important. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3516 W Harrison Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3516 West Harrison Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Amant Dicke

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	M.

6 (b) Name of husband or wife Joseph J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 16 1869

8. AGE: Years	Months	Days	If less than one day
77	7	4	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Wilson
13. Birthplace Richmond Va.

MOTHER
14. Maiden Name Elizabeth Shelton
15. Birthplace Va

16 (a) Informant Mr. Jos. J. Dicke
(b) Address 3516 W. Harrison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-23-47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md.

18 (a) Funeral director Leroy Boone
(b) Address 5005 Park Heights Ave

19 (a) APR 22 1947 (Date received by registrar) (b) Burlington Williamsburg Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20, 1947, at 8:15 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 0-0 1946 to 4-20 1947, and that I last saw h[illegible] alive on 4-10-1947.

Immediate cause of death
Arterio Sclerosis

Duration Uncertain

Due to Interval Growth
Tabernacular.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. A. Edmonds M. D.
Address 4-21-1947 Date signed

G50945

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G50945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2421 E. Eager St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2421 E. Eager St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Sachs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife John Sachs
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 20-1861

8. AGE: Years	Months	Days	If less than one day
76	3	1	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Adam Schmidt
13. Birthplace Germany

MOTHER
14. Maiden Name Not Known
15. Birthplace Germany

16 (a) Informant John G. Sachs
(b) Address 2421 E. Eager St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 24-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Belair Rd.

18 (a) Funeral director John A. Miller
(b) Address 23 E. Preston St. Baltimore, Md.

19 (a) APR 22 1947 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1947, at 5:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/13 1936 to April 21 1947, and that I last saw HER alive on April 20 1947.

Immediate cause of death	Duration
Arteriosclerosis - generalized	
Bronchopneumonia	3 days
Due to Myocardial degeneration	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis T. Klunes M. D.
Address 623 E. Monument St. Date signed 4/21/47

G50946

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √94a

G50946
Registered No.

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be entered. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 14 N. Linwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 14 N. Linwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oliver H. Eliason

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Laura H. Eliason
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 28 1872

8. AGE: Years	Months	Days	If less than one day
74	7	22	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Worked for Balt. City
11. Industry or business

FATHER
12. Name Eliason
13. Birthplace Not Known

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Laura H. Eliason
(b) Address 14 N. Linwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 23-47 (month) (day) (year)
(c) Cemetery or crematory Baltimore, Md.
Location North Ave & Gay St.

18 (a) Funeral director John A. Miller
(b) Address 2334 Jefferson St.

19 (a) 4-27-1941 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1947 at 9:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to Apr 20 1947 and that I NEVER last saw him alive on 19

Immediate cause of death Coronary Occlusion — Duration

Due to Arteriosclerosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles O. MacMinn M. D.
Address 2911 E. Belt St Date signed Apr 21 1947

VS 150

X Mac Minn

G50947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 195a

G50947 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be accurately correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland W. Fayette St
(b) Street address Bon Secours Hosp.
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 131-W-Lanvale (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME CHARLES NELSON DUGAN.

3 (b) If veteran, name war: No
3 (c) Social Security Account No.:

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed or divorced: Married

6 (b) Name of husband or wife: Prudence G. R. Dugan
6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) March 17-1872

8. AGE: Years 75 | Months 1 | Days 4 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimd. (Town, county, and state)

10. Usual Occupation Realestate

11. Industry or business —

FATHER 12. Name Cumberland Dugan
13. Birthplace Baltimd.

MOTHER 14. Maiden Name Harriett Buchanan
15. Birthplace Maryland.

16 (a) Informant Mrs C. N. Dugan-(wife)
(b) Address 131-W Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr-24-47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director Stuart Morgan Co
(b) Address 1028 W Lanvale St.

19 (a) APR 24 1947 (Date received by registrar) (b) Huntington Williams, M.D.

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 April 1947, at 4 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10 April 1947 to 21 April 1947 and that I last saw him alive on 21 April 1947.

Immediate cause of death: Cardiac failure — Duration: over

Due to: —

Due to: —

Other Conditions: None

(Include pregnancy within 3 months of death)

Date of operation: —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Joseph R. Libutti M. D.
Address Bon Secours Hosp Date signed 4/24/47

X

G50948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

G50948 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown Road Balto. 15, Md
(c) Hospital or institution: Mrs. Seton Institute
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30-10-13
(e) Length of stay in Baltimore (yrs., mos., or days) 30-10-13

2. USUAL RESIDENCE OF DECEASED:
(a) State Connecticut (b) County
(c) City or town Hartford (If outside city or town limits, write RURAL and give town)
(d) Street No. 140 Farmington Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rev. Francis L. Fitzpatrick

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-6-1874

8. AGE: Years 73 | Months 1 | Days 14 | If less than one day hr. min.

9. Birthplace Waterbury Connecticut (Town, county, and state)

10. Usual Occupation priest-author

11. Industry or business

FATHER 12. Name Jeremiah Fitzpatrick
13. Birthplace Ireland not certain

MOTHER 14. Maiden Name Catherine Fitzpatrick, Fitzpatrick
15. Birthplace Ireland

16 (a) Informant Mrs Seton Institute
(b) Address 6420 Reisterstown Rd., Balto. 15, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 23-47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Sherwood Morgan Co.
(b) Address 108 W North Ave.

19 (a) APR 22 1947 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/20 1947 at 12:12 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 1928 to 4/20 1947 and that I last saw h[illegible] alive on 4/20 1947

Immediate cause of death: Cardiovascular disease
Due to: Psychosis

Due to:

Other Conditions: Pernicious Anemia
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration
1 day
2 Wks.
30 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 332 Cathedral Signed

VS 150

G50949

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G50949 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2531 E. Monument St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7/12
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2531 E. Monument St., (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME CAROLINE (CARRIE) D. RINECKER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or ~~wife~~ Alexander Rinecker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/7/1872

8. AGE: Years	Months	Days	If less than one day
74	9	11	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Meier
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace w

16 (a) Informant Mrs. Frieda Selby - daughter
(b) Address 2531 E. Monument St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/22/47 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Baltimore Cemetery
Location Rose St.& North Ave.Balto.Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

APR 22 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 8 1947 to April 18 1947. and that I last saw h~~er~~ alive on April 18 1947.

Immediate cause of death: Apoplexy (Cerebral Hemorrhage) — Duration 10 days

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Pakerun M.D.
Address 2200 E. Madison Date signed 4/21/47

X

650950

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Register 650950

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St. City
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) Lyn Town
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1530 N. Gay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marguerite Neubauer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, widowed, or divorced.
Female	white	Widow ~~single~~

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 30, 1877

8. AGE: Years	Months	Days	If less than one day
70	0	22	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER
12. Name Phillip Zimmerman
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Wolf
15. Birthplace Germany

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St. City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-25th 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Leo G. Leo ch
(b) Address 1201-03 N. Patterson Park Ave

19 4-22 1947 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-21st 1947, at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April-1- 1947, to Ap-21- 1947, and that I last saw h~~e~~r alive on Ap-21- 1947.

Immediate cause of death	Duration
Edema Lungs	2 days
Due to Cerebral Hemorrhage	3 days
Due to	
Other Conditions Arterio Sclerosis	5 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E Gill Hall M. D.

Address 1631 E North Av Date signed 4/22/47

G50951

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1701c

Registered No. G50951

PLEASE WRITE PLAINLY, with UNFADING INK. Physicians: please write the correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1300 Diver Street. Rear
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES PATTON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 16, 1942

8. AGE: Years	Months	Days	If less than one day
4	5	4	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Envert Patton
13. Birthplace Virginia

MOTHER
14. Maiden Name Clara Clock
15. Birthplace Virginia

16 (a) Informant Clara Clock
(b) Address Virginia

17 (a) Burial (b) Date thereof 4-23rd 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Baltimore, Md

18 (a) Funeral director Leo. D. Leavitt
(b) Address 1701-03 N. Patterson Park Ave

19 (a) APR 22 1947 (b) Huntington Williams, M.D.
Date received by State Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20, 1947, at 2.25 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture skull with intracranial hemorrhage

Due to

Other Conditions Fracture left humerus and rupture of spleen
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 25/5

(a) Date of injury 4-20-47 at about 2 p M.
(b) Where did injury occur? West Bay Ave. near Diver St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Struck by auto

23. Signature Earl L. Kemp M.D.
Medical Examiner
Date signed 4-21-47

X

50952

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

S-50952
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1607 N Wolfe St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1607 N Wolfe St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick E. Hansge

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Minnie Hansge
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feby 4th 1873

8. AGE: Years	Months	Days	If less than one day
74	2	17	hr. min.

9. Birthplace Baltimore, (Town, county, and state)
10. Usual Occupation General
11. Industry or business Continental Can Co

FATHER
12. Name William Hansge
13. Birthplace Germany

MOTHER
14. Maiden Name Amelia Brandt
15. Birthplace Germany

16 (a) Informant Miss Louisa Hansge
(b) Address 1607 N. Wolfe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 25 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Rural

18 (a) Funeral director Ellrich Funeral Home
(b) Address 2008 Orleans St

APR 23 1947 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1947, at 3:50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William E. Holland M.D.
Medical Examiner.
Date signed 21 April 47

PLEASE WRITE PLAINLY WITH UNFADING INK. Fill in all blanks correctly. Give the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

G50953 Dr. Sawyer

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G50953

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3223 Chesterfield Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3223 Chesterfield Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward R. B. Mc Cabe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Lillian Mc Cabe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 5, 1886

8. AGE: Years	Months	Days	If less than one day
61	3	16	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name John Mc Cabe
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Lillian Mc Cabe
(b) Address 3223 Chesterfield Ave.

17 (a) Burial (b) Date thereof 4/24/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 (a) APR 22 1947 (b) Registrar
(Date rec'd by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 21, 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 29 1946 to Apr 21 1947 and that I last saw him alive on Apr 20 1947.

Immediate cause of death	Duration
Acute Coronary Occlusion	1 day
Due to Arteriosclerotic Heart Disease	2 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George Sawyer M. D.
Address 4808 Harford Rd. Date signed 4/21/47

X

Dr. Grenzer
1402 E. Lanvale St.

G50954

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. G50954

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1702 Crystal Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1702 Crystal Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard P. Dolan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Catherine E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1870

8. AGE: Years	Months	Days	If less than one day
76	11	8	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Edward Dolan
13. Birthplace Md.

MOTHER
14. Maiden Name ? Riley
15 Birthplace Md.

16 (a) Informant Mrs. Catherine E. Dolan
(b) Address 1702 Crystal Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/23/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) APR 22 1947 (Date received by Registrar) (b) Registrar for Williamsport, Md.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 20, 1947 at 8:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1940 to April 20 1947 and that I last saw h[illegible] alive on April 19 1947.

Immediate cause of death Arteriosclerotic C-V disease — Duration 10 yrs

Due to

Due to

Other Conditions Parkinson's Disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Grenzer
Address 1402 E. Lanvale St. Date signed Apr. 27-47.

X

G50955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G50955 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1416 Linden Ave.
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1416 Linden Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY STEVENSON CLOPPER

3 (b) If veteran, name war: none
3 (c) Social Security Account No. 219-05-6594

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Wm. A. Clopper
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 19, 1868

8. AGE: Years	Months	Days	If less than one day
78	5	1	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Clerk - retired
11. Industry or business U. S. F. & G. Co.

FATHER
12. Name Wesley Carretson Stevenson
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Agnes Quinlin
15. Birthplace Harford Co., Md.

16 (a) Informant Mr. H. Stevenson Clopper
(b) Address 2831 Ridgewood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/23/47 (month) (day) (year)
(c) Cemetery or crematory Fairview Cem.
Location Keedysville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) APR 22 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 20 1947, to Apr 20 1947, and that I last saw h[er] alive on Apr 20 1947.

Immediate cause of death	Duration
Coronary occlusion	4 hrs
Due to arteriosclerosis	Initial
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature G. Lenox Ewalt M. D.
Address 2945 N. Paul St Date signed Apr 22/47

X

G50956

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G50956 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2802 Allendale Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2802 Allendale Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER DUDLEY YATES

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Grace R. Yates
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 26, 1878

8. AGE: Years	Months	Days	If less than one day
69	0	25	hr. min.

9. Birthplace Centreville, R. I.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Walter J. Yates
13. Birthplace Rhode Island

MOTHER
14. Maiden Name Martha Read
15. Birthplace England

16 (a) Informant Mrs. Grace R. Yates, wife
(b) Address 2802 Allendale Rd.

17 (a) Cremation (b) Date thereof 4/24/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Crem.
Location Balto., Md.
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.
19 (a) APR 22 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1-1947 to 4-21 1947, and that I last saw h[illegible] alive on 4-20 1947.

Immediate cause of death	Duration
Cerebral hemorrhage.	2 hrs.
Due to Hypertension	4 mos
Due to Coronary Sclerosis.	—
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howard A. Warren M. D.
Address 2607 Garrison Blvd. Date signed 4-22-47

G50957

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 83a

Registered No. G50957

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: Univ Hosp 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2da
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 423 W Saratoga (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Howard W. Preston

3 (b) If veteran, name war --

3 (c) Social Security Account No. 217-01-0150A

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1878

8. AGE: Years	Months	Days	If less than one day
69	2	6	hr. min.

9. Birthplace Harford Co., Md. (Town, county, and state)
10. Usual Occupation -
11. Industry or business

FATHER
12. Name Robert A. Preston
13. Birthplace Harford Co., Md.

MOTHER
14. Maiden Name Sarah Rolls
15. Birthplace Harford Co., Md.

16 (a) Informant Miss Laura Preston
(b) Address 423 W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/23/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date received APR 22 1947 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/20 1947 at 10 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/18 1947, to 4/20 1947 and that I last saw him alive on 4/20 1947

Immediate cause of death Resp. Failure — Duration
Due to Cerebrovascular accident
Due to Hypertension & arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. B. Marshall Jr. M.D.
Address Univ Hosp Date signed 4/24/47

VS 150

G50958

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45a

G50958 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Caton Avenue
(c) Hospital or institution: Jenkins Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1000 Caton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME E. Finley Cromwell

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: Male

5. Color or race: W. White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Georgia M. Cromwell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3, 1855

8. AGE: Years 91 | Months 9 | Days 18 | If less than one day hr. min.

9. Birthplace Anne Arundel Co., Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Randolph S. Cromwell
13. Birthplace A. A. Co.

MOTHER
14. Maiden Name Elizabeth B. Stewart
15. Birthplace A. A. Co.

16 (a) Informant Miss Constance Cromwell
(b) Address 4023 Kathland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/24/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 APR 22 1947 (Date rec'd by Registrar) Junction for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1947, at 2:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/5/44 19 to 4/21/47 19; and that I last saw h[illegible] alive on 4/21 19 47.

Immediate cause of death: Cardiac failure — Duration
Due to: ACVD - grade
Due to: Arteriosclerosis
Due to: Epithelioma lower lip
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address [illegible] Date signed 4/21/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. This correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50959 FL 110056

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered G50959

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hr-10M
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 McCulloh St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Akins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widowed

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
60 ?	?	?	hr. min.

9. Birthplace S. C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Johnnie Akins
13. Birthplace ?

MOTHER
14. Maiden Name Emma ?
15. Birthplace S. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof 4/23/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvert
Location Baltimore Md

18 (a) Funeral director Charles F. Alexander
(b) Address 1200 McCulloh St.

19. (a) APR 22 1947 Huntington Williams M.D.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1947, at 4.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 20 1947, to April 20 1947, and that I last saw h. alive on April 20 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Lobar pneumonia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Doyle Waldron M. D.
Address B. C. H. Date signed 4-20-47

G50960

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G50960

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 627 George Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 17yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 627 George St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MATTIE McTIER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Walter McTier
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17, 1894

8. AGE: Years	Months	Days	If less than one day
53	-	4 2	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Jerry Brown
13. Birthplace N. C.

MOTHER
14. Maiden Name Unknown
15. Birthplace N. C.

16 (a) Informant Mr. Walter McTier
(b) Address 627 George St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-23-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery Cem
Location A. A. Co., Md.

18 (a) Funeral director Mrs Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) APR 22 1947 (Date rec'd by registrar) for Wellington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH April 19, 1947 at 8:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/27 1947 to 4/19 1947 and that I last saw h[illegible] alive on 4/17 1947.

Immediate cause of death	Duration
(a) Acute Myocarditis	1 day
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 45 W. Biddle St. Date signed 4/24/47

X

G50961

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 8-3a

Registered No. G50961

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2501 1/2 Eastern Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2501 1/2 Eastern Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Sliwka (Snifter)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife Veronica
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years About 64 | Months | Days | If less than one day hr. min.

9. Birthplace Poland.
(Town, county, and state)

10. Usual Occupation Laboer

11. Industry or business American Can Co.

FATHER
12. Name Stanley Sliwka
13. Birthplace Poland.

MOTHER
14. Maiden Name
15. Birthplace Poland

16 (a) Informant Hattie Huenemeyer
(b) Address 2501 1/2 Eastern ave

17 (a) Burial (b) Date thereof 4-24-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto. Co

18 (a) Funeral director Wm. J. Fialkowski
(b) Address 2007 Eastern Ave

19 APR 22 1947 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1947, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 20 1947 to April 21 1947 and that I last saw him alive on April 21 1947

Immediate cause of death: Hydrocephalus hemorrhage — Duration 36 hr.

Due to: Cerebral Thrombosis ?

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank J. Sturgis M. D.
Address 700 E. Fayette St. Date signed 4/24/47

VS 150

650962 Bk # B 76387 160a Reg. 650962

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 24
(If outside city or town limits, write RURAL and give town)
(d) Street No. 35 S. Elwood Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Alphonsa Ackerman Jr.

3 (b) If veteran, name war: No
3 (c) Social Security Account No. No

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Newborn
6 (b) Name of husband or wife: Newborn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20, 1947

8. AGE: Years | Months | Days: One | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Newborn
11. Industry or business

FATHER
12. Name Henry Alphonsa Ackerman
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Eleanor Stella Wisniewski
15. Birthplace Baltimore, Maryland

16 (a) Informant Mother
(b) Address 355 S. Elwood Ave, Baltimore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/23/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Druid Hill Ave.

18 (a) Funeral director Marie E. Featherstone
(b) Address 1000 S. Kenwood ave

19 (a) APR 22 1947 Huntington Williams Registrar
(Local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1947, at 3:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 20 1947, to April 21 1947, and that I last saw him alive on April 21 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Tentorial tear and Subarachnoid Hemorrhage	
Due to Birth injury	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy Subarachnoid Hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nicholas J. Kohlenmeyer M. D.
Address Church Home & Hosp. Date signed 4/21/47

X

C50963

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. C50963

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 719 Mapleton ave.
(c) Hospital or institution: 146

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 22 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 719 Mapleton ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harold Grantmyre

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 219-07-6690

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced. Married.
6 (b) Name of husband or wife Charlotte J. Grantmyre
6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) November 16-1904

8. AGE: Years 43 | Months 5 | Days 5 | If less than one day ____ hr. ____ min.

9. Birthplace Sidney Canada
(Town, county, and state)

10. Usual Occupation Electrician
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Wilson Grantmyre
13. Birthplace Canada

MOTHER
14. Maiden Name Mary Grantmyre
15. Birthplace Canada

16 (a) Informant Charlotte J Grantmyre Wife
(b) Address 719 Mapleton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/23/47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Rd.

18 (a) Funeral director M. W. E. Dyer's Son
(b) Address Howard & Gay Sts.

19 APR 22 1947 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 19 47, at 3 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 21 19 47 to April 21 19 47.
and that I last saw him alive on April 20 19 47.

Immediate cause of death: Carcinoma of Stomach — Duration: 3 mo
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation Apr 20 47
Major findings of operation: Inoperable Ca
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. F. A. Stevens M. D.
Address 2818 Harford Rd Date signed 4-21-47

V S 150

G50964

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. GE0964

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1628 E. 28th Street
(c) Hospital or institution: 9 E
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1628 E. 28th Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Frederick Henry Stienecke, Jr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-18-6175

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Annie Elizabeth Stienecke

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 7-1894

8. AGE: Years 52 | Months 4 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (city, county, and state)

10. Usual Occupation Butcher

11. Industry or business

FATHER 12. Name Frederick H. Stienecke

13. Birthplace Maryland

MOTHER 14. Maiden Name Lillian M. Murphy

15. Birthplace Maryland

16 (a) Informant Mrs. Annie E. Stienecke

(b) Address 1628 E. 28th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 23-1947 (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home

(b) Address 3631 Falls Road

19 (a) APR 22 1947 Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1947, at 8:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 13 Feb 1946 to 19 April 1947 and that I last saw him alive on 19 April 1947

Immediate cause of death: Coronary Occlusion Arteriosclerotic Cardio Vascular Disease — Duration 13 Feb '46

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas W. Edwards M. D.

Address 2776 The Alameda Date signed 21 April 47

Edwards X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G50965 Reg. No. 108294

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G50965

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-mo. 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 72 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 107 W. Monument St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (c) **FULL NAME** Ida May Telgkamp

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22nd 1872

8. AGE: Years 74 | Months 10 | Days 29 | If less than one day ... hr. ... min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Herman Telgkamp (D
13. Birthplace Germany

MOTHER
14. Maiden Name Sophia ### Flueger
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/24/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (Date received by local registrar) APR 22 1947 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION P M

20. DATE OF DEATH April 21st 1947, at 6.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 9th 47 to Apr. 21 1947, and that I last saw her alive on Apr. 21st 1947.

Immediate cause of death	Duration
Lymphosarcoma with widespread metastases	
Due to	
Due to	
Other Conditions Pathological fracture left femur and right tibia. (Include pregnancy within 3 months of death)	

Date of operation 3-27-47
Major findings of operation: Lymphosarcoma
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. T. Gibbs M. D.
Address Balt. City Hospitals Date signed 4/22/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. C50966

C50966 DC# B-71881

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mth 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 mth 26 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2121 Southern Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Flanagan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	White	Single

6 (b) Name of husband or wife none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 25, 1947

8. AGE: Years	Months	Days	If less than one day
	1	26	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name John Ernest Flanagan
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Winifred Ann Swain
15. Birthplace Pennsylvania

16 (a) Informant Hospital Records
(b) Address Union Memorial Hospital 33rd St. Baltimore Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-23-1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md.

18 (a) Funeral director Flynn & Flynn
(b) Address 1426 Light St.

19 APR 22 1947 (Date filed by Registrar) (b) Curington Williams, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1947, at 3:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 11 1947 to April 21 1947 and that I last saw him alive on April 21 1947

Immediate cause of death Aspiration of food — Duration several minutes

Due to

Due to

Other Conditions Subarachnoid hemorrhage from birth injury — 1 mth 26 days
(Include pregnancy within 3 months of death)

Date of operation April 9, 1947

Major findings of operation: cerebral edema

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public (Specify type of place) While at work?
(e) Means of injury

23. Signature Ernest V. deMoss M.D. M. D.
Address Union Memorial Hosp. Date signed 4-21-47

VS 150

G50967 BH# B-72317

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G50967

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address E. Monument St
(c) Hospital or institution: Sinai Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 1 3
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore - 17 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1918 W. North Ave (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Bressler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Wht	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 2, 1947

8. AGE: Years	Months	Days	If less than one day
10		0	hr. 2 min.

9. Birthplace Balto - Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jerome Bressler
13. Birthplace Pa.

MOTHER
14. Maiden Name Harriet Bressler
15. Birthplace N. C.

16 (a) Informant Harriet Bressler
(b) Address 1918 W. North Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School APR 18 1947
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 2, 1947 at 4:31 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 2 1947 to Mar. 2 1947 and that I last saw h[illegible] alive on Mar. 2 1947

Immediate cause of death Respiratory failure — Duration

Due to Atelectasis

Due to Prematurity

Other Conditions Mother is hyperthyroid

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Isaiah Hospital M. D.
Address Date signed 4-11-47

G50968 BC#G75134 BALTIMORE CITY HEALTH DEPARTMENT ✓ G50968
Registered No.

CERTIFICATE OF DEATH 160a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address E. Monument St
(c) Hospital or institution: Jewish
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Mos
(e) Length of stay in Baltimore (yrs., mos., or days) 4 Mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto - 17
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2026 Md. Royal Terr
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa Frances De Vito

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Wht
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APR. 5, 1947

8. AGE: Years: NB. Months: Days: 23 If less than one day ..... hr. ..... min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph De Vito
13. Birthplace Balto - Md.

MOTHER
14. Maiden Name Betty Wagner
15. Birthplace Balto West Va

16 (a) Informant Betty De Vito
(b) Address 2026 Mt. Royal Ter.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School APR 1 8 1947

18 (a) Funeral director Commissioner of Health
(b) Address
APR 22 1947 (Date received by registrar) (Signature of registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 8 1947, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 8 1947 to Apr 8 1947 and that I last saw her alive on Apr 8 1947

Immediate cause of death	Duration
Hyaline membrane Respiratory failure	6 hours
Due to Atelectasis	30 hrs
Due to	
Other conditions Congenital Pneumonia	hours

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address Hopkins Hosp Date signed Apr 8

V S 150

X

G50969

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G50969

Bk # B72228 159

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address E. Monument St
(c) Hospital or institution Sinai Hosp [illegible]
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 8 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore-17 (If outside city or town limits, write RURAL and give town)
(d) Street No. 2219 Brookfield Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy "B" Fink

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Wht

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1947

8. AGE: Years 0 Months Days If less than one day 8 hrs min.

9. Birthplace Balto - Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Jack Raymond Fink
13. Birthplace Balto - Md

MOTHER 14. Maiden Name Sadie Jeannie Cohen
15. Birthplace Balto - Md

16 (a) Informant Sadie Fink
(b) Address 2219 Brookfield Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location Johns Hopkins Medical School APR 18 1947

18 (a) Funeral director Commissioner of Health

(b) Address

APR 22 1947 Thos. Williams M.D.
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23 1947, at 5:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 22 1947 to Feb. 23 1947, and that I last saw him alive on Feb. 23 1947

Immediate cause of death	Duration
Respiratory failure	
Due to Atelectasis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Aylin M. D.
Address Sinai Hospital Date signed 4-11-47

X

G50970 Dft #-12227

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G50970 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address E. Monument St
(c) Hospital or institution: Sinai 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr
(e) Length of stay in Baltimore (yrs., mos., or days) 1 hr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - 17 (If outside city or town limits, write RURAL and give town)
(d) Street No. 2219 Brookfield Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy A. Fink

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Wht | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1947

8. AGE: Years 0 | Months | Days | If less than one day 1 hr. min.

9. Birthplace Balto - Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Jack Raymond Fink
13. Birthplace Balto - Md.

MOTHER 14. Maiden Name Sadie Jennie Askin
15. Birthplace Balto - Md.

16 (a) Informant Sadie Fink
(b) Address 2219 Brookfield Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School APR 18 1947
Commissioner of Health

18 (a) Funeral director
(b) Address

19 APR 22 1947 (Date rec'd by registrar) (Signature) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 22, 1947 at 0-35 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 22 1947 to Feb. 22 1947, and that I last saw him alive on Feb. 22 1947

Immediate cause of death: Respiratory failure — Duration
Due to Atelectasis
Due to Prematurity
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Askin M. D.
Address Sinai Hospital Date signed 4-11-47

X

G50971

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BCH 873432 161a

G50971 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address E. Monument St
(c) Hospital or institution Sinai Hosp, 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore — (If outside city or town limits write RURAL and give town)
(d) Street No. 2246 E. Chase St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Ihle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 17, 1947

8. AGE — Years | Months | Days | If less than one day 10 hr. 45 min.

9. Birthplace Balto - Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Jacob Ihle
13. Birthplace Balto - Md.

MOTHER 14. Maiden Name Barbara Baker
15. Birthplace Balto - Md

16 (a) Informant Barbara Ihle
(b) Address 2246 E. Chase St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Johns Hopkins Medical School APR 18 1947

18 (a) Funeral director Commissioner of Health

(b) Address

APR 22 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 110

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 18, 1947 at 2:45 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 18 1947 to Mar 18 1947, and that I last saw him alive on Mar. 18 1947.

Immediate cause of death Respiratory failure — Duration

Due to Atelectasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Ayler M. D.
Address Sinai Hospital Date signed 4-18-47

G50972

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BC# Bz 72840 161a

G50972 ✓ Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address E. Monument St

(c) Hospital or institution: Sinai

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 1 0

(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore 17 (If outside city or town limits, write RURAL and give town)

(d) Street No. 2034 Brookfield Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Boy Reamer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	wht.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 28, 1947

8. AGE: Years	Months	Days	If less than one day
10			1 hr. min.

9. Birthplace Balto - Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Sidney Reamer

13. Birthplace Balto - Md

MOTHER 14. Maiden Name Ann Brodbeck

15. Birthplace Balto - Md

16 (a) Informant Ann Reamer

(b) Address 2034 Brookfield Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Lo Johns Hopkins Medical School APR 18 1947

18 (a) Funeral director Commissioner of Health

(b) Address

APR 22 1947 (Date rec'd by Registrar) Huntington Williams, M.D.

VS 180 10-46

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28 1947, at 10 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 28 1947 to Feb. 28 1947, and that I last saw h. alive on Feb. 28 1947

Immediate cause of death Respiratory failure — Duration

Due to Atelectasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Samuel Auerbach, M. D.

Address Sinai Hospital Date signed 4-16-47

X

G50973

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BC# 16721 161a

G50973 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7. Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto - 14 (If outside city or town limits, write RURAL and give town)
(d) Street No. 2806 White Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Appel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: wht | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 20, 1947

8. AGE: Years | Months | Days | If less than one day: 6 hr. 20 min.

9. Birthplace Balto - Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Frederick L. Appel
13. Birthplace Balto Md

MOTHER 14. Maiden Name Catherine Nowenska
15. Birthplace Balto - Md

16 (a) Informant Catherine Appel
(b) Address 2806 white Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School APR 18 1947

18 (a) Funeral director Commissioner of Health
(b) Address

APR 22 1947 (Date received by registrar) Hamilton Williams M.D.

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 20, 1947 at 6:25 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 20 19 47 to Mar 20 19 47 and that I last saw him alive on Mar. 20, 19 47.

Immediate cause of death: Respiratory failure — Duration

Due to: Atelectasis

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Levine M.D.
Address Sinai Hospital Date signed 4-19-47 M. D.

X

G50974

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G50974 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hosp - Y
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 551 W. Barre St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ashby HENRY LEE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Katie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years 50 | Months | Days | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Henry Lee
13. Birthplace Va

MOTHER
14. Maiden Name Mary Johnson
15. Birthplace Va

16 (a) Informant Katie Lee
(b) Address 557 W Barre St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 24 47 (month) (day) (year)
(c) Cemetery or crematory Betts National Cem
Location Baltimore Md

18 (a) Funeral director David L Brown Son
(b) Address 1084 Montgomery St Huntington Northumberland Md

19 (a) Date received (Registrar) APR 22 1947 (b) Registrar

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21, 1947, at 12 AM VS

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Left cerebral thrombosis.

Edema of lungs

Due to Myocardial hypertrophy

Myocardial scarring.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.

Date signed 4/21/47

REPLACEMENT
4-50975

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 186a

Registered No. 4-50975

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct and especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: South Baltimore General Hospital 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 637- W. Lee Street.
(If rural give location)
(e) Citizen of foreign country? .....(Yes or No)
If yes, name country .....

3 (a) FULL NAME CHARLES RANKIN

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widowed

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
65			..... hr. ..... min.

9. Birthplace Essex Co. Va.
(Town, county, and state)
10. Usual Occupation Scowe man
11. Industry or business Not known

FATHER
12. Name Not known
13. Birthplace

MOTHER
14. Maiden Name Not known
15. Birthplace

16 (a) Informant Stanford Carter
(b) Address 637- W.Lee St.

17 (a) Burial (b) Date thereof April 29, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Occupation
Location Virginia

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantly Avenue

19 (a) 4-22-47 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18, 1947 at 10.45 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary edema

Due to Myocardial degeneration

Other Conditions 1- Multiple fractures of ribs, right
2- Chronic pancreatitis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☒ cause of death, fill in the following:
(a) Date of injury 4-16-47 ? M.
(b) Where did injury occur? Chesapeake Lighterage Co.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Fell from scow

23. Signature Earl L Ryder M.D.
Medical Examiner
Date signed 4-19-47

VS 191

G50976

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G50976
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 Hilton St.
(c) Hospital or institution: Hebburton Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1Mo
(e) Length of stay in Baltimore (yrs., mos., or days) 75 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3625 Springdale Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eva W. Cooper

3 (b) If veteran, name war —
3 (c) Social Security Account No. None

4. Sex F
5. Color or race W.
6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 4-1857

8. AGE: Years 89 Months 6 Days 17 If less than one day hr. min.

9. Birthplace Dorchester Co Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Wm Abby Cooper
13. Birthplace Md

MOTHER
14. Maiden Name Margaret Lee
15. Birthplace Md

16 (a) Informant Mrs W. Lemmon
(b) Address 3625 Springdale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 23-47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Balto Md

18 (a) Funeral director Peters & Boyle
(b) Address 222 W. Baltimore St

19 (a) APR 22 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21st 1947, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 29 1947, to April 21 1947, and that I last saw h. alive on March 29 47

Immediate cause of death	Duration
Myocarditis	
Due to Senile Cog	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
(f) Signature John A Evans M. D.
Address 6 E Mt Vernon Pl Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G50977.

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G50977.
Registered No.

CERTIFICATE OF DEATH 52B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: UNIV HOSP
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State VA. (b) County BRUNSWICK
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLARENCE M. BOWEN

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife MYRLE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace BRUNSWICK Co. VA. (Town, county, and state)
10. Usual Occupation FARMER.
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APRIL 24-47 (month) (day) (year)
(c) Cemetery or crematory PHILADELPHIA CHURCH
Location BRUNSWICK Co.
18 (a) Funeral director Chas. H. Williams
(b) Address Lawrenceville, Va.
APR 23 1947 (b) Huntington for Williams, Mgr.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 April 1947, at 2:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7 NOV 1946, to 22 APR 1947, and that I last saw h. ... alive on 22 APR 1947.

Immediate cause of death	Duration
CARCINOMA OF BLADDER	
& LIVER METASTASIS	
Due to HYDRO URETER & NEPHROSIS	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: SAME

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E. Bames M. D.
Address Univ. Hospital Date signed 22 Apr 47

X

650978

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

49a

Registered No. 650978

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Walker Ave
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Maryland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 14 Ballman Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Mell (CURRAN)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married, widowed, or divorced~~
Female	White	Married

6 (b) Name of husband or wife Herman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/5/94

8. AGE: Years	Months	Days	If less than one day
49	11 9	16	hr. min.

9. Birthplace N. Y.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Peto
13. Birthplace N. Y.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Ann Covell
(b) Address 14 Ballman Court Brooklyn

17 (a) Burial (b) Date thereof 4/24/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

APR 23 1947
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/21 19 47, at 11:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/12 19 47 to 4/21 19 47 and that I last saw h[illegible] alive on 4/21 19 47

Immediate cause of death	Duration
Adenocarcinoma	
Due to Ovary with	
Due to metastases	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry W. Hodges M. D.
Address [illegible] Date signed 4-21-47

G50979

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G50979 Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland + Rayner Ave
(c) Hospital or institution: West Balto Gen'l Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3075 Collins Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Sadie E. BARRETT

3 (b) If veteran, name war: W

3 (c) Social Security Account No. 212-05-1746

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3, 1884

8. AGE: Years 63 | Months | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Chief Operator

11. Industry or business Telephone Co

FATHER
12. Name John Barrett
13. Birthplace Washington D.C.

MOTHER
14. Maiden Name Mary E. Graves
15. Birthplace Maryland

16 (a) Informant Sandy Garrett
(b) Address 907 S. Collins Ave

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 4-26-47 (month) (day) (year)

(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Milburn Co Inc
(b) Address 2174 Gay (Street and number)

APR 23 1947 (Date filed by registrar) Washington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-21 1947 at 845 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-20 1947 to 4-21 1947 and that I last saw her alive on 4-21 1947

Immediate cause of death: CEREBRO-VASCULAR Hemmorrhage — Duration

Due to: Hypertensive Cardio Vascular Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Berkowitz M. D.
Address West Balto Sta Date signed 4-21-47

VS 150

C50980

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52B

Reg. No. C50980

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 743 N. Kenwood Ave.
(c) Hospital or institution: **********
(d) Length of stay in hospital or inst. (yrs., mos., or days) ****
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 743 N. Kenwood Ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH S. SCHELLE

3 (b) If veteran, name war: W.W.I.
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife: Ida Taylor Schelle
6 (c) If alive, give age D. years

7. Birth date of deceased (mo., day, yr.) Aug. 4th. 1892

8. AGE: Years	Months	Days	If less than one day
54	8	15	********** min.

9. Birthplace: Baltimore Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name: Peter T. Schelle
13. Birthplace: Baltimore Maryland

MOTHER
14. Maiden Name: Mary J. Allan
15. Birthplace: Baltimore Maryland

16 (a) Informant: Mrs. Cordelia Ward
(b) Address: 2728 E. Monument Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Apr. 23/47 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cemetery
Location: Baltimore Maryland

18 (a) Funeral director: C. Gilbert & Son
(b) Address: 1300 Eutaw Place..17

APR 23 1947 (Date rec'd by registrar)

(b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 April 19 47 at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to April 19th 1947 and that I last saw him alive on April 19 1947

Immediate cause of death: Carcinoma of bladder
Due to: myocardial failure
Due to: —

Duration — 2 yrs
4/17/47

Other Conditions: Marked anemia - mitral + aortic insufficiency — 10 m.
(Include pregnancy within 3 months of death)

Date of operation: about 2 years ago
Major findings of operation: Carcinoma of bladder
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Louis F. Krumrein
Address: 722 N. Kenwood Ave Date signed 4/24/47

G50981 CMK-87985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G50981

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGIN RESERVED FOR BINDING. Physicians: please write the correct age is especially important. the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2- 11- 8-
(e) Length of stay in Baltimore (yrs., mos., or days) 4 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 515 N. Longwood Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Dugan

3 (b) If veteran, name war

3 (c) Social Security Account No. 119-01-1376

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8-1890

8. AGE: Years	Months	Days	If less than one day
57	0	13	hr. min.

9. Birthplace New York
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Dugan
13. Birthplace New York

MOTHER
14. Maiden Name Ellen Coady
15. Birthplace New York

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/24/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director MARTIN FAHEY & SONS
(b) Address 1827 W. North Ave.

APR 23 1947
Local registrar Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 19 47 at 10:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 13 19 44 to Apr. 21 19 47, and that I last saw her alive on April 21 19 47.

Immediate cause of death: Lobar Pneumonia, Bilateral — Duration: Days

Due to

Due to

Other Conditions Gastric Ulcer with massive Hemoptysis — ?
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Lobar Pneumonia Gastric ulcer.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edmund B. Beacham M. D.
Address Balto City Hosp Date signed 4/24/47

X

G50982

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered No. G50982

MARGIN RESERVED — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Sinai Hospital Baltimore Md 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 69 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County.....
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2214 Lake Ave
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME George C. Beckman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 9/28/78

8. AGE: Years	Months	Days	If less than one day
68	6	29	.....hr. .....min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name Phillip D Beakman
13. Birthplace Balto

MOTHER
14. Maiden Name Mary Winkler
15 Birthplace Balto

16 (a) Informant George Beckman
(b) Address 2214 Lake Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/25/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.
18 (a) Funeral director Tully & Zeiler Inc
(b) Address 403 S Broadway St

19 (a) ..... (Date received by registrar) (b) Livingston Williams M.D.

APR 29 1947

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 19 47, at 11:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 27 19 47 to April 22 19 47 and that I last saw h[illegible] alive on April 22 19 47.

Immediate cause of death	Duration
Uremia	
Bronchopneumonia	
Hypostasis & Pneumonia	
Due to Carcinoma of bladder	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation April 15, 1947
Major findings of operation: Carcinoma bladder
of autopsy: Metastasis hypostasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury..... TRAUMA
23. Signature Louis H Dale M. D.
Address Sinai Hospital Date signed April 29 1947

X

G50983

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G.50983 Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Lovert and Saratoga
(b) Street address Mercy
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 50 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALT. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2710 FAIT AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JULIUS H. ROMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife HANNA ROMAN
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) JULY 30, 1885

8. AGE: Years	Months	Days	If less than one day
61 62	9 8	22 23	hr. min.

9. Birthplace PA. (Town, county, and state)
10. Usual Occupation FOREMAN
11. Industry or business

FATHER
12. Name JOSEPH ROMAN
13. Birthplace GERMANY

MOTHER
14. Maiden Name AGNES BUTLER
15. Birthplace GERMANY

16 (a) Informant Joseph Roman - son
(b) Address 2814 Orleans St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/25/47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location German Hill Rd

18 (a) Funeral director Lilly & Zeltz
(b) Address 403 S. Eutaw St

Filed APR 23 1947 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-22 1947, at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-8 1947 to 4-22-1947 and that I last saw him alive on 4-22 1947

Immediate cause of death	Duration
CARDIAC FAILURE	
Due to MYOCARDIAL DEGENERATION	
Due to	
Other Conditions CARCINOMA SIGMOID - PERFORATION WITH ABSCESS (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy CARCINOMA SIGMOID WITH PERFORATION AND ABSCESS AND METASTASIS TO LIVER.

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James A. Roberts M.D. M. D.
Address Mercy Hospital Date signed 4-22-47

VS 150

93D

G50984

Addent

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G50984 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette and Calhoun
(c) Hospital or institution: Frank. Sq. Hosp. 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 415 S. Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Ludwig Ajdent

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	widowed

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 25, 1889

8. AGE: Years	Months	Days	If less than one day
57	5 7	3 28	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation ~~Tailor~~ Tailor
11. Industry or business

FATHER
12. Name Casimer Ajdent
13. Birthplace Poland

MOTHER
14. Maiden Name
15. Birthplace Poland

16 (a) Informant Mrs. Helen Novak
(b) Address 415 S. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/26/47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto. Co.

18 (a) Funeral director Wm. B. Fialkowski
(b) Address 2007 Eastern Ave.

APR 23 1947 (Date received by registrar) (b) Washington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1947, at 8:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 22 1947, to April 22 1947, and that I last saw him alive on April 22 1947.

Immediate cause of death	Duration
Cardiac Decompensation	?
Due to Arteriosclerotic heart disease	?
Due to	
Other Conditions Chronic glomerulo nephritis	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Stanley B. Olszewski M.D.
Address Frank. Sq. Hosp. Date signed 4-22-47

937

G50985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH . 13B

Registered No. G50985

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2727 Fait ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2727 Fait Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard F Riemer

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-05-5838

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced.~~
Male	White	

6 (b) Name of husband or wife Isabelle Riemer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30 1914

8. AGE: Years	Months	Days	If less than one day
32	10	22	hr. min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Riemer
13. Birthplace Germany

MOTHER
14. Maiden Name Mary F Kemp
15. Birthplace Balto

16 (a) Informant Mrs Isabelle Riemer
(b) Address 2727 Fait ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-24-47 (month) (day) (year)
(c) Cemetery or crematory St Matthias
Location Balto

18 (a) Funeral director J J Herr & Son
(b) Address 3001 Kentucky ave

19 (a) Apr 23 1947 (b) Huntington W Va
(Signature of local registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/21/47 1947 at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/20 1947 to 4/21 1947
and that I last saw h. alive on 4/20 1947

Immediate cause of death	Duration
Tuberculosis, chronic, pulmonary	4 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Manuel E Shut M. D.
Address 1626 N. Carlton St Date signed 4/22/47

G50986

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

+55c ✓ Registered No. G50986

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2036 Griffis Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Ferndale Md
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Elizabeth Gates

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female. 5. Color or race: White. 6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Harry H Gates

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 13 - 1874.

8. AGE: Years 72 Months 6. Days 8 If less than one day hr. min.

9. Birthplace Lebanon Pa.
(Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER 12. Name Phillippy

13. Birthplace Lebanon Pa

MOTHER 14. Maiden Name Susan Phillippy

15. Birthplace Lebanon Pa

16 (a) Informant Mr. Harry H Gates

(b) Address 527 E. Cold. Spring Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 24 47 (month) (day) (year)

(c) Cemetery or crematory Meadow Ridge Mem. Location Baltimore Md

18 (a) Funeral director Augustus C. Pyfer

(b) Address 1600 W. North Ave

19 APR 23 1947 (b) Huntington Williamsport Md.
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1947 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2, 1947 to April 24 1947, and that I last saw h[illegible] alive on April 24 1947.

Immediate cause of death Pulmonary thrombosis

Due to Carcinoma of Sigmoid flexure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration between onset and death: 3 mo.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. V. Rangle

Address 642 North Blvd Date signed 4-23-47

R. V. Rangle X

VS 150

C 50987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C50987

Every item of information should be carefully supplied. Write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 409 Pontiac Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward (Starcks) Stroh

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07-4691

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Anna Belle Pumphrey
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Jan 23, 1887

8. AGE: Years	Months	Days	If less than one day
60	2	29	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business Car Wheel Co.

FATHER
12. Name William Stroh
13. Birthplace Md

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Anna Belle Stroh
(b) Address 409 Pontiac Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/25/47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd.

18 (a) Funeral director John F Glenny Sue
(b) Address 715 Light St.

19 (a) APR 23 1947 (Received by Registrar) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1947 at 2 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, spontaneous

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D. (Medical Examiner)
Date signed 4-22-47

Waiting for Williams Mar

VS 181

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C50988

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46F

Registered No. C50988

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1224 S. Cleveland St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1224 S. Cleveland St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John R. Fallon

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No. 215-01-3628

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary E. Fallon

6 (c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.) Oct. 9, 1890

8. **AGE:** Years: 56 | Months: 6 | Days: 13 | If less than one day: hr. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: Paint Painter

11. Industry or business: Athey Paint Co.

FATHER
12. Name: William Fallon
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Clara Hoffman
15. Birthplace: Md.

16 (a) Informant: Mary E. Fallon
(b) Address: 1224 S. Cleveland St.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 4/25/47 (month) (day) (year)
(c) Cemetery or crematory: Balto. National Cem.
Location: Frederick Ave.

18 (a) Funeral director: Joseph T. Simbro Jr.
(b) Address: 714 N. Franklintown Rd.

19 (a) Date rec'd APR 23 1947 (b) Registrar: Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1947 at 8:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 1st 1947 to Apr. 22 1947, and that I last saw h[illegible] alive on Apr. 19 1947.

Immediate cause of death	Duration
Due to: Unknown	
Due to: Carcinoma of the lung	2 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Louis P. Trundy M. D.

Address: 1014 E. Pratt St. Date signed 4/22/47

X

G50989

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH · 132

G50989 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Provident Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 111 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 905 Saratoga St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha V. Stuart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Henry L. Stuart

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 13, 1915

8. AGE: Years 31 | Months 8 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Clifton Goynes.
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary Ferguson.
15. Birthplace Baltimore, Md.

16 (a) Informant Henry L. Stuart.
(b) Address 905 W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 24 1947 (month) (day) (year)
(c) Cemetery or crematory Arlington Memorial
Location

18 (a) Funeral director Mrs. Katie R. Wilkins
(b) Address 322 N. Schroeder St.

19 (a) APR 23 1947 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1947, at 10:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 9 1947, to April 20 1947, and that I last saw him alive April 20 1947.

	Duration
Immediate cause of death: Tuberculous Meningitis	
Due to: Miliary Tuberculosis	
Due to:	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. P. Howell M. D.
Address 600 W. Barrett St. Date signed 4/23/47

G50990

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

133 B

Registered No. G50990

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 918 Sharp St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Keys

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: N | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Clacy Keys

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/10/98

8. AGE: Years 48 | Months 10 | Days 11 | If less than one day: hr. min. 2

9. Birthplace Weldon, N.C. (Town, county, and state)

10. Usual Occupation Stevedore

11. Industry or business

FATHER: 12. Name Richard Keys.
13. Birthplace N.C.

MOTHER: 14. Maiden Name Lillie Waldon,
15. Birthplace N.C.

16 (a) Informant Clacy Keys,
(b) Address 534 W. Lee St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 25 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

APR 23 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/21 1947, at 9:37 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/2 1947, to 4/21 1947, and that I last saw him alive on 4/21 1947.

Immediate cause of death Uremia — Duration

Due to Polycystic Kidneys

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Polycystic Kidneys

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. H. Bagwell M.D.
Address Roland Ave. Date signed 4/23/47

G50991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G50991

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 McElderry St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2025 McElderry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dora A. Chamberlain

3 (b) If veteran, name war	3 (c) Social Security Account No.
No.	No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Widowed

6 (b) Name of husband or wife John B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 3 1881

8. AGE: Years	Months	Days	If less than one day
65	6	19	hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER 12. Name Andrew Lastner
13. Birthplace Balto

MOTHER 14. Maiden Name Cicelia Haiso
15. Birthplace Balto.

16 (a) Informant Elmer Lawrence Chamberlain
(b) Address 2025 McElderry St.

17 (a) Burial (b) Date thereof 4/24/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd.

18 (a) Funeral director M. W. C. Dignal & Sons
(b) Address Lombard & Penn Sts.

19 (a) 1347 [illegible] Washington Blvd Balto MD

V S-150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1947, at 10:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1947, to April 22 1947, and that I last saw h. alive on April 21 1947.

Immediate cause of death	Duration
Coronary	3 Weeks
Due to Throm bosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Pokorny
Address 2200 E Madison St Date signed 4/23/47 M.D.

MARGIN RESERVED FOR FILING. Every item of information should be carefully supplied. PLEASE WRITE PLAINLY, WITH UNFADING INK. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C50992

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C50992

183

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Anne Arundel
Found- Arundel on the Bay- Maryland.
(a) State (b) County
(c) City or town Annapolis
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DOROTHY ATKINSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Vernon Atkinson

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 9-1908

8. AGE: Years	Months	Days	If less than one day
38	6	11	hr. min.

9. Birthplace Deantsville Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Wm Ed. Stearnes

13. Birthplace Va.

MOTHER 14. Maiden Name Sarah Whitehurst

15. Birthplace

16 (a) Informant Richard Vernon Atkinson

(b) Address Virginia Beach Va

17 (a) Buried (b) Date thereof 4/24/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location Norfolk Va.

18 (a) Funeral director John C Keary

(b) Address 2407 Pinkney [illegible]

19 (a) Date received APR 23 1947 (b) Registrar Huntington Williams, M.D.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20, 1947, at 11.30 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 4-20-47 at about 11. a. M.
(b) Where did injury occur? Found Arundel on Bay, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Found drowned

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 4/21/47

G50993 BH G-72618 BALTIMORE CITY HEALTH DEPARTMENT G50993
CERTIFICATE OF DEATH 182a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4206 Rasp Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4206 Rasp Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joan Diane Frank

3 (b) If veteran, name war No
3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Mar. 3, 1947

8. AGE: Years | Months 1 | Days 19 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John Frank
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Carrie A. Halloran
15. Birthplace Baltimore Md.

16 (a) Informant Mr. & Mrs John Frank
(b) Address 4206 Rasp Ave

17 (a) Burial (b) Date thereof 4-24-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Baltimore, Md.

18 (a) Funeral director Henry Sander & Sons Inc.
(b) Address North Ave. & Broadway

APR 23 1947 (b) Williams Mill
(Registrar) Entered by

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1947 at 5:35 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Mechanical suffocation

Due to

Other Conditions Upper Respiratory Infection
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 26/1
(a) Date of injury 4-22-47 at 3 P M.
(b) Where did injury occur? 4206 Rasp Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury suffocation by bedclothes

23. Signature [signature] M.D.
Medical Examiner.
Date signed 4-22-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 181

G50994

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G50994 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MARYLAND GENERAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Wash (b) County D C
(c) City or town Washington D C.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1201 Kingwood Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RAYMOND L. ROSS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sarah Th.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6 1880

8. AGE: Years 67 | Months | Days 16 | If less than one day ____hr. ____min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation Map Maker

11. Industry or business Dept of Commerce

FATHER 12. Name Archibald Ross

13. Birthplace Canada

MOTHER 14. Maiden Name ——— White

15. Birthplace Unknown

16 (a) Informant Rev Edwin A. Ross

(b) Address 7428 Brambleton Rd. Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/25/47 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location Wash D C.

18 (a) Funeral director H. W. Meagerson

(b) Address 849 N. Calvert St.

APR 23 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/22 19 47 at 4.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/11 1947 to 4/22 1947, and that I last saw him alive on 4/22 1947.

	Duration
Immediate cause of death HYPERTENSIVE CARDIOVASCULAR DISEASE	11 DAYS
Due to	
Due to	
Other Conditions CHRONIC PURULENT SINUSITIS (RIGHT) (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles W. Stewart, Jr., M.D.
Address Md. Gen. Hosp. Date signed 4/22/47

G50995

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G50995 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2428 Linden Ave
(c) Hospital or institution: 13

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2428 Linden Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Herzfeld

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Leva
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 17-1872

8. AGE: Years 74 | Months 4 | Days 5 | If less than one day hr. min.

9. Birthplace Russia (town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Hersch
13. Birthplace Russia

MOTHER
14. Maiden Name Etta
15. Birthplace Russia

16 (a) Informant Bernard H Herzfeld
(b) Address 2428 Linden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-23-47 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Herzug Ass'n Inc

18 (a) Funeral director Jacob Leuthe Inc
(b) Address 1439 E Balto St.
(c) Filed by registrar Washington Williams M.D. Registrar

APR 23 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1947, at 7 00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1947 to April 22 1947, and that I last saw h[illegible] alive on April 22 1947.

Immediate cause of death: Arteriosclerotic Heart Dis — Duration: 1 yr
Senility -
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D L Smith M. D.
Address 1223 E North Ave Date signed 4/23/47

VS 150

X

G50996

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G50996
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1706 Dundalk Avenue
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - 24
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1706 Dundalk Avenue
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME John A. Witonski

3 (b) If veteran, name war
3 (c) Social Security Account No. 214-01-5299

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of ~~husband~~ wife Victoria
6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) Jan. 15, 1905

8. AGE: Years	Months	Days	If less than one day
42	3	7	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Printer
11. Industry or business The Horn-Shafer Co.

FATHER
12. Name John Witonski
13. Birthplace Unknown

MOTHER
14. Maiden Name Eva Hadzicki
15. Birthplace Unknown

16 (a) Informant Mrs. Victoria Witonski
(b) Address 1706 Dundalk Avenue

17 (a) Burial (b) Date thereof 4-25-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location Baltimore County, Md.

18 (a) Funeral director George A. Weber
(b) Address 700 S. Ann Street

19 (a) (b)
(Date and registrar)

APR 25, 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 22 1947, at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from APRIL 21 1947 to April 22 1947, and that I last saw h~~im~~ alive on APRIL 22 1947.

Immediate cause of death	Duration
CORONARY THROMBOSIS	3 DAYS
Due to HYPERTENSIVE C.V. DISEASE	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stafford C. Mackenzie M.D.
Address 6714 Holabird Ave Date signed 4/23/1947

X

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

10909 G50997 CERTIFICATE OF DEATH ✓ 50

Registered No. G50997

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo-7days
(e) Length of stay in Baltimore (yrs., mos., or days) 11yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 634 W. Fayette Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Ann Sullivan

3 (b) If veteran, name war
3 (c) Social Security Account No. 175-12-0016

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Separated

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 26- 1905

8. AGE: Years	Months	Days	If less than one day
41	4	23	hr. min.

9. Birthplace Scotland (Town, county, and state)
10. Usual Occupation Laundry
11. Industry or business Employee

FATHER
12. Name David Miller (D
13. Birthplace Scotland

MOTHER
14. Maiden Name Jennie Baird
15. Birthplace Scotland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 24/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Frederick Rd.
18 (a) Funeral director Edward Foulson
(b) Address 2359 Wash. Blvd. Balto. Md.
19 (a) (Date received by registrar) Huntington Williams (registrar)

APR 23 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1947, at 3.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-18- 1947, to 4-19 1947, and that I last saw her alive on 4-19 1947.

	Duration
Immediate cause of death Carcinoma Rt Breast &	18 Mo
Metastases (Generalized)	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation About one year ago
Major findings of operation: Ca of Breast.
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature H. Cutler M. D.
Address City Hospitals Date signed 4-23-47

X

(3) G50998

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 93D

G50998

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Catholic City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7D
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (or foreign country)
(b) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(c) Street 529 Oldham
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALBERT MOESSINGER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Maria M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 28-1883

8. AGE: Years	Months	Days	If less than one day
64	6	24	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Merchant

11. Industry or business

FATHER
12. Name Unk
13. Birthplace Germany

MOTHER
14. Maiden Name Unk
15. Birthplace Germany

16 (a) Informant Mrs Maria Moessinger

(b) Address 529 Oldham St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 25-47 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Taylor Ave

18 (a) Funeral director John L Connolly

(b) Address 416 Eastern Ave

APR 23 1947 (Date rec'd by registrar)

(Huntington for Williams, M.D.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/22/47 19 12:35 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Intracerebral Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Evans M.D.
Medical Examiner.

Date signed 4/23/47

VS 131

G50999

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 125 B

G50999 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St Josephs Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 710 E 33 ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Vitale

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	MARRIED

6 (b) Name of husband or wife Paul

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-18-84

8. AGE: Years	Months	Days	If less than one day
62	11	3	hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Antonio Jones

13. Birthplace Italy

MOTHER 14. Maiden Name Anna Epstola

15. Birthplace Italy

16 (a) Informant St. Joseph Hosp

(b) Address Caroline & Oliver Sts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 25-1947 (month) (day) (year)

(c) Cemetery or crematory Most Holy Redeemer Cem

Location Belair Road

18 (a) Funeral director Joseph Farace Inc

(b) Address 2013 B Fremont Ave

APR 23 1947 (b) Registrar

Registered by registrar Covington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 April 1947, at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-23 1947 to 4-21-1947, and that I last saw h[illegible] alive on 4-21-1947.

Immediate cause of death Cardio-Respiratory Failure — Duration

Due to Sepsis

Due to Hepatitis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations: Hepatitis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Bowles M.D.

Address Hosp Date signed 4-21-47 M. D.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51000

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

G51000 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2714 Maple St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Magruder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, 1884

8. AGE: Years	Months	Days	If less than one day
62	9	12	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business A & P Tea Co

FATHER
12. Name Robert Magruder
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Katherine Hargadon
15. Birthplace Ireland

16 (a) Informant Mercy Hosp.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/24/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto Co Md

18 (a) Funeral director L. Vernon Lemmon
(b) Address 4611 Park Heights Ave

19 (a) APR 23 1947 (Date rec'd by registrar) Huntingtown Williamsport Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1947, at 10:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-25 1947 to 4-20 1947, and that I last saw h.... alive on 4-20 1947.

Immediate cause of death Carcinoma of head of the pancreas — Duration

Due to

Due to

Other Conditions Diabetes Mellitus
(Include pregnancy within 3 months of death)

Date of operation 4-2-47

Major findings of operations Inoperable Carcinoma Metastasis

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward P. Smith M.D. M. D.

Address Mercy Hospital Date signed 4-20-47

VS 150

G51001

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G51001 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Delaware & Dawne St
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos.,~~ or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Upperco (Rural)
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David E. Bosley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Bessie Wilhelm

6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Jan 19-1885

8. AGE: Years 62 | Months 3 | Days 4 | If less than one day ____hr. ____min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER 12. Name Henry Bosley
13. Birthplace Md

MOTHER 14. Maiden Name Emma Brothers
15. Birthplace Md

16 (a) Informant Mrs David E Bosley
(b) Address Upperco Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 25/47 (month) (day) (year)
(c) Cemetery or crematory Mt Zion
Location Balto Co Md

18 (a) Funeral director Edw. A Tipton
(b) Address Hampstead Md

19 (a) APR 23 1947 (Date registered) Thurlington Williams (Local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1947, at 12-45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 12 1947 to April 23 1947, and that I last saw him alive on April 23 1947.

Immediate cause of death Congestive heart failure — Duration

Due to Coronary occlusion (?)

Due to

Other Conditions Arteriosclerosis & bronchitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles R Holman

Address Univ. Hospital Date signed 4/25/47

PLEASE WRITE PLAINLY. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51002 — AB-109349

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G51002 — Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29days
(e) Length of stay in Baltimore (yrs., mos., or days) 7yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1215 Greenmount Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Tarr

3 (b) If veteran, name war

3 (c) Social Security Account No. 205-01-3478

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 26- 1899

8. AGE: Years	Months	Days	If less than one day
48	1	25	hr. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation Housework
11. Industry or business Private Family M.80

FATHER
12. Name Clarence Oettig (D
13. Birthplace Pa.

MOTHER
14. Maiden Name Irene (D
15. Birthplace Pa.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 4/24/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balt Md

18 (a) Funeral director Frank Della Rose
(b) Address 52 N. Liberty St

19 (a) (b)
(Date rec'd by registrar) (Registrar)

APR 23 1947

MEDICAL CERTIFICATION AM

20. DATE OF DEATH April 21 1947, at 4.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-22- 1947 to 4-21 1947, and that I last saw her alive on 4-21 1947.

Immediate cause of death	Duration
Gentle Nevus -	
Prlyagia Congestion of Lungs	24 hrs
Due to Pulmonary Inflammatory	
Carcinoma of Left Breast	3 Mo
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: None
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. R. Butler M. D.
Address City Hosp Date signed 4-22-47

G51003

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G51003
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1232 Edith Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARGARET THOMAS ELICKSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Sep.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1906

8. AGE: Years 41 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Thomas Chase

13. Birthplace Md

MOTHER 14. Maiden Name Allice Chase

15. Birthplace Md

16 (a) Informant Samuel E. Chase

(b) Address 1232 Edith st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April (month) 1947 (day) (year)

(c) Cemetery or crematory Md Gateway Mem

Location Brooklyn Md

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Brantley ave

19 (a) Filed by registrar Thurlington Williams M.D. (b) Registrar

APR 23 1947

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/20/47 19 , at 3:07 p M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Res death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cor Pulmonary Edema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John R Peters M.D. Medical Examiner.

Date signed 4/21/47

G51004

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G51004 Registered No. 2698

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 2nd. Fl.
(b) Street address 523 Hoffman St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 523 Hoffman St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No.

3 (a) FULL NAME Rose Hilton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15, 1896

8. AGE: Years 51 | Months 3 | Days 5 | If less than one day hr. min.

9. Birthplace Georgia (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Henry Maddox
13. Birthplace Georgia

MOTHER
14. Maiden Name Unknown
15. Birthplace Georgia

16 (a) Informant William Baden
(b) Address 1722 Mc Dean

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/24/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill, Md.

18 (a) Funeral director A. Galatro
(b) Address 918 Druid Hill Ave.

19 (a) [illegible] 1947 (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20, 1947, at 11 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-1- 1946 to 4-20- 1947 and that I last saw her alive on 4-19 1947

Immediate cause of death Myocarditis — Duration unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jas. H. Saunders M. D.
Address 829 N. Stricker Date signed 4-24-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

G51005

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G51005 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MARYLAND GENERAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1817 Wilkens Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MINNIE A. GIMBEL

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-22-9694

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ late John H
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 18, 1894

8. AGE: Years	Months	Days	If less than one day
52	4	4	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Laber Lady
11. Industry or business Knitting Mill

FATHER
12. Name John Klein
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Richards
15. Birthplace Germany

16 (a) Informant Mrs Robert Gimbel
(b) Address 1817 Wilkens Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 26 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3301 Frederick Ave

18 (a) Funeral director Harry N Wilke
(b) Address 4101 Edmondson Ave

APR 23 1947 (Date received by registrar) Huntington Williams M.D. Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/22 1947, at 11 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/22 1947, to 4/22 1947, and that I last saw H.E.R. alive on 4/22 1947.

Immediate cause of death	Duration
CEREBRAL VASCULAR ACCIDENT	
Due to	
Due to	
Other Conditions HYPERTENSION	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles N Stewart M.D.
Address Md. Gen. Hosp. Date signed 4/22/47

S G51006 / 1225

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G51006 Registered No. 9012

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 715 Brookwood Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George W. Andrews
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife –
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 3-24-24
8. AGE: Years 23 Months 0 Days 27 If less than one day hr. min.
9. Birthplace Md (Town, county, and state)
10. Usual Occupation –
11. Industry or business –

FATHER 12. Name John N. Andrews
13. Birthplace Md
MOTHER 14. Maiden Name Gertrude Katz
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof April 24 '47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Frederick Ave
18 (a) Funeral director Henry H. Wolfe
(b) Address 4101 Edmondson Ave
19 (a) APR 23 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1947, at 11:30 A M
21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 18 1947 to Apr. 21 1947 and that I last saw him alive on Apr. 21 1947.

	Duration
Immediate cause of death: Myocardial failure	24 hrs
Pneumothorax	7 days
Due to: Chronic Constrictive Pericarditis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 4/17/47
Major findings of operation: Chronic Constrictive Pericarditis
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature [illegible] M.D.
Address 1154 Date signed 4/21/47

VS 150

G51007 Prager G51007

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 102

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette ST.
(c) Hospital or institution: Bon Secours. 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) All.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt.
(c) City or town Balt.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 219 N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Gertrude Prager.

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-07-6678

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Divorced

6 (b) Name of husband or wife Geo. J. Prager
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-19-05

8. AGE: Years	Months	Days	If less than one day
41	10	4 5	hr. min.

9. Birthplace Balt - Balt. Md.
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Edward V. Dunn
13. Birthplace Md

MOTHER
14. Maiden Name Julia C Mc Cauley
15. Birthplace Md.

16 (a) Informant Mrs Gertrude C Dunn
(b) Address 2336 W Lexington St

17 (a) Burial (b) Date thereof April 26 '47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St Peters
Location 1301 Frankland Ave

18 (a) Funeral director Harry A Wiltse
(b) Address 4101 Edmondson Ave

19 (a) (b)
(Date rec'd by registrar) Thurston Williams, Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1947, at 1:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1947, to April 22 1947, and that I last saw h[illegible] alive on April 22 1947.

Immediate cause of death	Duration
Cardiac failure	
Due to	
Due to	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James Alt Wardlaw, Jr., M. D.
Address Bon Secours Hospital Date signed April 23 1947

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51008

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G51008 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: University 19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1811 N. Henry St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Gertrude Carson

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-01-7452

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	married

6 (b) Name of husband or wife Arthur Carson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 29, 1895

8. AGE: Years	Months	Days	If less than one day
51	5	23	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Joseph Schoenman

FATHER
12. Name Michael Hauk
13. Birthplace Maryland

MOTHER
14. Maiden Name Hanna Atkinson
15. Birthplace Maryland

16 (a) Informant Mrs. Arthur Carson
(b) Address 1811 N. Henry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/26/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto, Md.

18 (a) Funeral director Harry A. Wiltze
(b) Address 4101 E. Lombard Ave

19 (a) 4-23 1947 (Date rec'd by registrar) (b) Washington Hollinger, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-22-47 1947, at 1:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-21 1947, to 4-22 1947, and that I last saw h[illegible] alive on 4-22 1947.

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Pomeroy Bucknell M.D.
Address Univ. Hosp. Date signed 4-22-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51009

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G51003 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MARYLAND GENERAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4003 Fernhill Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN WALTER CHEW

3 (b) If veteran, name war -

3 (c) Social Security Account No. -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Etta E. Chew

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15, 1869

8. AGE: Years	Months	Days	If less than one day
78	-	7	hr. min.

9. Birthplace West River, Md. (Town, county, and state)

10. Usual Occupation -

11. Industry or business -

FATHER
12. Name Summerfield Chew
13. Birthplace West River, Md.

MOTHER
14. Maiden Name Sallie Plake
15. Birthplace West River, Md.

16 (a) Informant Mrs. Etta E. Chew
(b) Address 4003 Fernhill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/24/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 APR 23 1947 (Date received by registrar) Thurlington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/22 1947, at 8:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/21 1947, to 4/22 1947, and that I last saw him alive on 4/22 1947.

Immediate cause of death	Duration
ARTERIOSCLEROTIC HYPERTENSIVE CARDIO-VASCULAR DISEASE C	1 DAY
Due to PULMONARY EDEMA AND ACUTE FAILURE	
Due to	
Other Conditions LEFT INGUINAL HERNIA; EMPHYSEMA	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles M. Stewart, M. D.
Address MD. GEN. HOSP. Date signed 4/22/47

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51010

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G51010 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3432 Mondawmin Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city & town limits, write RURAL and give town)
(d) Street No. 3432 Mondawmin Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Martin Boone

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Anna Boone (nee Cannon) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23, 1863

8. AGE: Years: 84 | Months: 0 | Days: 0 | If less than one day: hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Clerk

11. Industry or business: Superior Court Balto. City

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden Name: Virginia Ford
15. Birthplace: Unknown

16 (a) Informant: Mrs. May A. Boone, wife
(b) Address: 3432 Mondawmin Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/26/47 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) APR 28 1947 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1947, at 5:15 P M

21. I certify that I took charge of the remains described above, held an Autopsy on Ed Davis thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Occlusion

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: William J. Kelsch M.D. Medical Examiner
Date signed April 23, 1947

VS 181

G51011

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

10

G51011 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harford Rd at Herring Run
(c) Hospital or institution:
Sydenham Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 417 N. Madeira (If rural give location)
(e) Citizen of foreign country? no Madeira (Yes or No)
If yes, name country

3 (a) FULL NAME Kolar, Geraldine

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12 Feb. 1941

8. AGE: Years 6 | Months 2 | Days 10 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Kolar, Jerome
13. Birthplace Baltimore

MOTHER
14. Maiden Name Emmel, Alma
15. Birthplace Baltimore, Md.

16 (a) Informant Father
(b) Address 417 N. Madeira St. Balt, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 25/47 (month) (day) (year)
(c) Cemetery or crematory Oak Hill Cem.
Location Towson Md.

18 (a) Funeral director John J. Miller
(b) Address 2334 Jefferson St.

APR 23 1947 (Date filed by registrar) (b) Clinton Hill Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1947, at 1:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 19 1947 to April 22 1947, and that I last saw her alive on April 22 1947.

Immediate cause of death	Duration
Myocarditis	
Due to Diphtheria	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature T. Duncan Robinson M. D.
Address Sydenham Hosp. Date signed 4/27/47

G51012

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G51012 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard and Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4100 Groveland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Jane Bowser

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Wilson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1865

8. AGE: Years	Months	Days	If less than one day
81	3	28 29	hr. min.

9. Birthplace N. Carolina
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Anderson Maxwell
13. Birthplace N. C.

MOTHER
14. Maiden Name Rosa Badger
15. Birthplace N. C.

16 (a) Informant Miss Martha G. McMillan
(b) Address 4100 Groveland Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4/24/47 (month) (day) (year)
(c) Cemetery or crematory --
Location West Jefferson, N. C.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

APR 23 1947 (Date rec'd by registrar) (b) Washington, N.C. Registrar

VS 150

MEDICAL CERTIFICATION

20. **DATE OF DEATH** 4/23/ 1947 at 6 50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/5 1947 to 4/23 1947.
and that I last saw h.e.s. alive on 4/23 1947.

Immediate cause of death	Duration
Ca of Lung	
Intestinal Obstruction	
Dilatation - emaciation	
Due to Pneumonia Right base -	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Y. Mazenburg Jr. M. D.
Address University Hospital Date signed 4/25/47

G51013

BALTIMORE CITY HEALTH DEPARTMENT

BC# b75939 CERTIFICATE OF DEATH 159

Registered No. G51013

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1002 N. Wolfe (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Baby Girl Coffee

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 4-14-47

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name William Coffee
13. Birthplace Va

MOTHER
14. Maiden Name Janet Page
15. Birthplace Va

16 (a) Informant Recorder
(b) Address JOHNS HOPKINS HOSPITAL

17 (a)..... (Burial, cremation, or removal) (b) Date thereof..... (month) (day) (year)
(c) Cemetery or crematory.....
Location Johns Hopkins Medical School APR 16 1947

18 (a) Funeral director Commissioner of Health
(b) Address.....

APR 23 1947 (Date rec'd by Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1947, at 11 20 AM

21. I certify that death occurred on the date above stated, that I attended deceased from April 14 1947 to April 15 1947 and that I last saw h[illegible] alive on Apr 14 1947.

Immediate cause of death Asphyxiation
pneumonia

Due to.....

Due to.....

Other Conditions Premature
Atelectasis
(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
of autopsy:.....

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature Eugenie Daniels M.D.
Address Johns Hopkins Hosp. Date signed 4-15-47 M. D.

X

G51014

BC# D76006

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

161a

15165 G51014
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1702 W. Lanvale Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alston

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14, 1947

8. AGE: Years	Months	Days	If less than one day
			11 hr. 45 min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace ?

MOTHER
14. Maiden Name Edith Sewell
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address JOHNS HOPKINS HOS...

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Johns Hopkins Medical School APR 16 1947
Location

18 (a) Funeral director Commissioner of Health
(b) Address

19 APR 23 1947 (Registrar) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14, 1947, at 8:20P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 14 1947 to April 14 1947 and that I last saw her alive on April 14 1947.

Immediate cause of death	Duration
Congenital anomalies (achrondroplasia)	
Due to Atelectasis lungs bilateral	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Russell Arden M. D.
Address Johns Hopkins Hospital Date signed 4-15-47

VS 150

G51015

BC# B81489

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH V159

Registered No. G51015

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Corner Redmond & Greene St.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 7 da

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give locality)
(d) Street No. 1024 Leadenhall St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Fannie Johnson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 4/9/47

8. AGE: Years	Months	Days	If less than one day
0	0	7	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Selim Dana
13. Birthplace S. C.

MOTHER
14. Maiden Name Hagar Johnson
15. Birthplace S. C.

16 (a) Informant Hagar Johnson
(b) Address 1024 Leadenhall St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School APR 21 1947

18 (a) Funeral director Commissioner of Health
(b) Address Washington Hill
APR 23 1947 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16, 1947 at 8:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 9 1947 to April 16 1947, and that I last saw her alive on April 16 1947.

Immediate cause of death Prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Hoff M. D.
Address University Hosp. Date signed 4-16-47

VS 150

X

G61016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G61016 Registered No. 94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3917 Fairmount ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3917 Fairmount ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida mary Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband ~~or wife~~ Edward J Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 3. 1878

8. AGE: Years 69 | Months 2 | Days 20 | If less than one day hr. min.

9. Birthplace Balto md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John H Peters
13. Birthplace Balto md

MOTHER
14. Maiden Name Alberta E Hommann
15. Birthplace Balto md.

16 (a) Informant Katherine Campbell
(b) Address 3917 Fairmount ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 23 1947 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem
Location Balto

18 (a) Funeral director George Wheatley
(b) Address 2203 Edmondson ave

APR 23 1947 (Signature of local registrar) (b) Catonsville, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 21 1947, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 27 1946 to Apr 21 1947, and that I last saw h alive on Apr 19 1947.

Immediate cause of death	Duration
Coronary Thrombosis	Sudden
Due to Hypertension + arteriosclerosis.	Several Yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M Bernard Hood M. D.
Address 2200 Garrison Blvd Date signed 4/24/47

VS 150

Dr. Stevens
Harford & Hugo Ave.

G51017

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

131a

Registered No. G51017

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1711 Abbottston Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1711 Abbottston Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry E. Rogers

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-09-7065

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Bessie M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 9, 1873

8. AGE: Years	Months	Days	If less than one day
74	3	11	hr. min.

9. Birthplace Harford Co. Md.
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name James Rogers
13. Birthplace Md.

MOTHER
14. Maiden Name Martha Grafton
15. Birthplace Md.

16 (a) Informant Mrs. Bessie M. Rogers
(b) Address 1711 Abbottston Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/23/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road 14

19 (a) (b) (Signature by registrar) Registrar

APR 23 1947

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 20, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from april 10 1947 to april 20 1947 and that I last saw her alive on april 20 1947.

Immediate cause of death	Duration
Bronchial Pneumonia	2 d.
Uraemic Coma	4 d.
Due to Arterio Sclerosis	10 d.
Hypertension	10 d.
Due to Mitral Regurgitation Decompensated	10 d.
Other Conditions Chr. Interstitial Nephritis	10 d.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature G. F. A. Stevens M. D.
Address 2878 Harford Rd Date signed 4-21-47

92 B

G51018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G51018 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 924 Little Pine St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 924 Little Pine St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VIRGINIA JONES

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 20, 1894

8. AGE: Years	Months	Days	If less than one day
53	2	29	hr. min.

9. Birthplace Mathews, Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Minter
13. Birthplace Va.

MOTHER
14. Maiden Name Agnes ?
15. Birthplace Va.

16 (a) Informant Mrs. Theodosia Mangostn
(b) Address 924 Little Pine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-25-47 (month) (day) (year)
(c) Cemetery or crematory
Location Lee Hall, Virginia

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (Filed by registrar) (b) Registrar

APR 23 1947

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH April 19, 1947 at 7:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 17 1947 to April 19 1947 and that I last saw him alive on April 19 1947.

Immediate cause of death: Pulmonary Tuberculosis — Duration 2 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. H. Watts
Address 5454 Huntington Ave. Date signed 4/22/47

Huntington Williams, M.D.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G51019

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 137 Liegwart Lane
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 137 Liegwart Lane (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ora Robert Trout

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mildred Ethel Trout
6 (c) If alive, give age 27 years

7. Birth date of deceased (mo., day, yr.) March 23, 1879

8. AGE: Years 68 | Months — | Days 29 | If less than one day: hr. min.

9. Birthplace: Fort Wayne, Indiana (town, county, and state)
10. Usual Occupation: Surveyor
11. Industry or business: Retired

FATHER
12. Name: Frank J. Trout
13. Birthplace: Indiana

MOTHER
14. Maiden Name: Anna Heathman
15. Birthplace: Indiana

16 (a) Informant: Mildred Ethel Trout
(b) Address: 137 Liegwart Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-24-47 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore, Maryland

18 (a) Funeral director: George L. Schnyl
(b) Address: 2101 Frederick Ave.

19 APR 24 1947 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21, 1947, at 7:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from MARCH, 1946, to April, 1947, and that I last saw him alive on 4/21, 1947.

Immediate cause of death: Acute Cardiac Failure — Duration: 1 hour

Due to: Myocardial Insufficiency — YEARS

Due to: Arteriosclerosis, Generalized. — YEARS

Other Conditions: Obesity — YEARS

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: H. H. Williamson M.D.

Address 2126 Frederick Ave. Signed 4/24/47

X

C51020
CWK-109682

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. C51020

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 63- 3- 12-

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
5 City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2604 Lehman Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jeanette Ellis

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Separated
6 (b) Name of husband or wife: William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 10-1884

8. AGE: Years 63 | Months 3 | Days 12 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name George Wolfe
13. Birthplace Maryland

MOTHER
14. Maiden Name Ora Ellis
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-25-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director George L. Jakwab
(b) Address 2101 Frederick Ave.

APR 24 1947 (Date rec'd by Registrar)
(b) Huntington Nolldiwe, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1947, at 4:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 6 1947 to Apr. 22 1947, and that I last saw h er alive on Apr. 22 1947.

Immediate cause of death	Duration
Bronchopneumonia	1 week
Due to Organic ren dat. Hypertension Cardio vascular	?
Due to Disease	?
Other Conditions Emphysema, Pulmonary due to Ut dat. cause (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Laurence Lee Jr. M. D.
Address Baltimore City Hosp. Date signed 4-22-47

X

G5.1021

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 186a

Registered No. G5.1021

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital 27-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6515 Edna Ave
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Julian C. Somers

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed or divorced~~
Male	White	Married

6 (b) Name of husband or wife Goldie B. Somers
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Feb 14th 1882

8. AGE: Years	Months	Days	If less than one day
65	2	7	.....hr. .....min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Chief Hydrographer
11. Industry or business U. S. Navy

FATHER
12. Name Howard M. Somers
13. Birthplace New Haven, Conn.

MOTHER
14. Maiden Name Julia Foote
15. Birthplace Unknown

16 (a) Informant Howard P. Somers
(b) Address 45 Delrey Ave Catonsville Md

17 (a) Burial (b) Date thereof 4/24/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 217 E. Paul St

19 (a) APR 24 1947
(Date rec'd by registrar)
Remington for Baltimore, Md.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21st 1947, at 5:30 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary thrombosis
Bronchopneumania
~~Due to~~ Fracture right humerus
Fractured ribs

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury 4-17-47 at about 6:30 P. M.
(b) Where did injury occur? Camden R.R. Station
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Fell from platform to track

23. Signature George P. Merrill M.D.
Medical Examiner.
Date signed 4-22-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51022

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G51022

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1623 Chilton St.
(c) Hospital or institution: 9-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1623 Chilton St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Charles Franz

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-01-1052

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mildred G. Franz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 24th 1899

8. AGE: Years	Months	Days	If less than one day
48	1	29	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Vice President
11. Industry or business Flynn - Emrich Co

FATHER
12. Name John B. Franz
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary A. Wagner
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Mildred G. Franz
(b) Address 1623 Chilton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/26/47 (month) (day) (year)
(c) Cemetery or crematory Balto. Md.
Location

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 APR 24 1947 (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23rd 1947, at 8:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 14 1947 to April 18 1947, and that I last saw him alive on April 18 '47

Immediate cause of death	Duration
Coronary occlusion	4 hrs (?)
Due to arterio-sclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Louis J. Timmerm M. D.
Address 722 N. Fremont Ave Date signed 4/24/47

G51023

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G51023

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 59yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1550 Sheffield Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Emma Heath

3 (b) If veteran, name war: NH
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife: Walter R. Heath
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/25/87

8. AGE: Years	Months	Days	If less than one day
59	9	28	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Walter H. Watson
13. Birthplace Bolivar W. Va.

MOTHER
14. Maiden Name Emma T. Carr
15. Birthplace Portsmouth Va.

16 (a) Informant Walter Heath
(b) Address 1550 Sheffield Rd.

17 (a) Burial (b) Date thereof 4/26/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 APR 24 1947 (b) Huntington Williams, M.D.
(Date received by Registrar) (Address)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/23 1947 at 2:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/7 1947 to 4/23 1947
and that I last saw h[illegible] alive on 4/23 1947.

Immediate cause of death	Duration
Cardio-Respiratory Failure	
Due to Metastatic Carcinoma of Liver	
Due to Carcinoma of Stomach	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Carcinoma of Stomach with metastasis of autopsy: To Liver

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M.D.
Address St. Joseph Hosp. Date signed 4/23/47

VS 150

G51024

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937 ✓

G51024 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden + Madison Sts
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town) 11-2
(d) Street No. 530 W. Charles St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cornelius P. Kuhan

3 (b) If veteran, name war Korea

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~ Married

6 (b) Name of ~~husband or~~ wife Mamie Kuhan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 4 1878

8. AGE: Years 69 | Months 3 | Days 19 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Foreman

11. Industry or business B & O R. R.

FATHER 12. Name Cornelius P. Kuhan
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Mary E. Morwood
15. Birthplace Md.

16 (a) Informant Mamie Kuhan
(b) Address 530 W. Charles st.

17 (a) Removal (b) Date thereof 4/24/47 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery ~~or crematory~~ Moundsville
Location W. Va.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St.

19 (a) APR 24 1947 Filed by Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/23/47 19 at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/18/1947 to 4/23/1947 and that I last saw him alive on 4/23/1947.

Immediate cause of death Heart failure — Duration 5 days

Due to Terminal bronchopneumonia

Due to A. C. V. Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. E. Gonzales M. D.
Address Maryland Gen. Hosp. Date signed 4/25/47

VS 150

C51025

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

Registered No. C51025

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Cayuga & Dukeland
(c) Hospital or institution: West Balt. Gen. Hosp. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2800 Hilldale Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis M Lubin

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	White	married

6 (b) Name of husband or wife Marguerite
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years	Months	Days	If less than one day
59			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation merchant
11. Industry or business

FATHER
12. Name Joseph
13. Birthplace Russia

MOTHER
14. Maiden Name Freida
15. Birthplace Russia

16 (a) Informant Marguerite Rubin
(b) Address 2800 Hilldale Ave

17 (a) Burial (b) Date thereof 4-24-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Herzl-Friendship Cem
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 1496 Balto St

19 APR 24 1947 Huntington Williams, M. D.
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 April 1947 at 2:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 29 March 1947 to 23 April 1947, and that I last saw him alive on 23 April 1947.

Immediate cause of death	Duration
Respiratory Failure	
Due to Generalized Carcinomatosis	
Due to Ca. of Oesophagus	
Other Conditions Hydronephrosis, left	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lester A. Hall Jr. M. D.
Address West Balto Gen Hosp Date signed 4/24/47

VS 150

G51026

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G51026

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3419 E Pratt St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3419 E Pratt St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dora Frances Means

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Howard Means
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) July 29 1861

8. AGE: Years	Months	Days	If less than one day
66	1	24	..... hr. ..... min.

9. Birthplace Jamestown Md
(Town, county, and state)
10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name John Dorsey
13. Birthplace Md

MOTHER
14. Maiden Name Susan McClane
15. Birthplace Md

16 (a) Informant Miss Delma Means
(b) Address 3419 E Pratt St

17 (a) Burial (b) Date thereof Apr 26
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Rural

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans

19 (a) APR 24 1947 (b) Frantzington for Williams, M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 23 1947; at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1947 to 4/23 1947 and that I last saw h[illegible] alive on 4/23/1947.

Immediate cause of death: Cerebral Thrombosis 4 days
Due to: Arteriosclerosis & Stomach
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration: 2 Yrs 3 Mos

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wright D. Judkins M.D.
Address 3323 E Baltimore St Date signed 4/24/47

VS 150

G51027

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G51027

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1708 W. Franklin

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1708 W. Franklin St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Sophie Cornish.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C.	Widow

6 (b) Name of husband or wife Aaron Cornish

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5, 1874.

8. AGE: Years	Months	Days	If less than one day
73	1	15	hr. min.

9. Birthplace Taylor's Island, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name William Wilson

13. Birthplace Taylor's Island, Md.

MOTHER

14. Maiden Name Elizabeth

15. Birthplace Taylor's Island Md.

16 (a) Informant Mrs Elizabeth Pratt

(b) Address 1708 W. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 24 1947 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Mrs. K. R. Williams

(b) Address 322 N. Schroeder St.

19 (a) APR 24 1947 Kerrington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1947, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 7, 1947, to April 20, 1947, and that I last saw her alive on April 17, 1947.

Immediate cause of death	Duration
Arteriosclerosis	
Due to Senile degeneration	
Due to	
Other Conditions Arteriosclerotic heart disease	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature C. F. Campbell M. D.

Address 718 Dolphin St. Date signed 4-22-47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51028

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G51028
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1832 Ashland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-4
(e) Length of stay in Baltimore (yrs., mos., or days) 34yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1832 Ashland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Smith

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fem	Negro	married

6 (b) Name of husband or wife Ed Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10, 1912

8. AGE: Years	Months	Days	If less than one day
35	1	11	hr. min.

9. Birthplace Woodward S. C.
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business own home

MOTHER / FATHER
12. Name Lewis Moore
13. Birthplace South Carolina
14. Maiden Name Rena Davis
15. Birthplace South Carolina

16 (a) Informant Ed Smith
(b) Address 1832 Ashland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 24th (month) (day) (year)
(c) Cemetery or crematory Winnsboro S.C.
Location S.C.

18 (a) Funeral director Elroy O Wilson
(b) Address 1090 Pentlarge

19 (a) (b)

APR 24 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 19 47 at 8:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-24 1945 to April 15 1947
and that I last saw h.. alive on 4-21 1947

Immediate cause of death Carcinoma of Breast — Duration 2 yrs 9 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. K. Adams M. D.
Address 1222 N. Caroline Date signed 4-23-47

X

G51029

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30E

Registered No. G51029

AB-109758

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 5-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 124 N. Exeter Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Stewart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21- 1884

8. AGE: Years 62 | Months 9 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Stewart
13. Birthplace Maryland

MOTHER
14. Maiden Name Pricilla ?
15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/24/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County, Md.

18 (a) Funeral director Joseph B. Locke Jr.
(b) Address 1304 N. Central Ave

19 (Date rec'd by registrar) APR 24 1947 Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20- 1947, at 4.10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-9- 1947, to 4-20- 1947, and that I last saw him alive on 4-20- 1947.

	Duration
Immediate cause of death: Myocardial Insufficiency	?
Due to: Syphilitic Cardiovascular Disease with aortic insufficiency	?
Due to:	
Other Conditions: Hypertension or Arterio-sclerotic C.V.D.	?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.
Address Baltimore City Hosp. Date signed 4-22-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G51030

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G51030

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2403 Druid Hill Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2403 Druid Hill Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Imogine Brown Martin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	C.	MARRIED

6 (b) Name of husband or wife Floyd
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 20, 1900

8. AGE: Years	Months	Days	If less than one day
46	8	2	hr. min.

9. Birthplace Wash., D. C.
(Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name SAMUEL BROWN
13. Birthplace Md.

MOTHER
14. Maiden Name Albert, nee DAVIS
15. Birthplace WASH., D. C.

16 (a) Informant FLOYD MARTIN
(b) Address 2403 DRUID HILL AVE.

17 (a) BURIAL (b) Date thereof 4-25-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory HARMONY
Location WASH. D. C.

18 (a) Funeral director Joseph S. Locke
(b) Address 1304 N. Central Ave

19 (a) APR 24 1947 Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-22 1947 at 8 15 P M

21. I certify that death occurred on the date above-stated; that I attended deceased from Apr 1 1947 to Apr 22 1947 and that I last saw h[illegible] alive on Apr 22 1947

Immediate cause of death Carcinoma of Stomach

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] Pleasants M.D.
Address 2329 [illegible] Date signed Apr 25 1947

VS 150

X

G51031

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered G51031

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp. 28-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5201 Bellville Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Peter E. R. Braun

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Margaret Braun (nee Grebe) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1897

8. AGE: Years	Months	Days	If less than one day
50	3	1	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Car Operator
11. Industry or business Balto. Transit Co.

FATHER
12. Name Jacob Braun
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmia Kuprian
15. Birthplace Germany

16 (a) Informant Mrs. Margaret Braun
(b) Address 5201 Belleville Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/26/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Maryland

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) APR 24 1947 (Date rec'd by registrar) (b) Huntington Mackenzie, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-23 1947, at 10:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-10-47 19 to 4-23 1947, and that I last saw him alive on 4-23- 1947.

Immediate cause of death METASTATIC CARCINOMA OF THE BLADDER — Duration 6 MOS.
Due to
Due to — over
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: METASTATIC CARCINOMA RIGHT NEPHRECTOMY

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Lerman
Address Sinai Hospital Date signed 4-23-47 M. D.

G51032

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered No. G51032

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St
(c) Hospital or institution: So. Balto. Gen'l Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) 71 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2500 Pimlico Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sidney Wasserman

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. widower

6 (b) Name of husband or wife Gussie Wasserman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24 1876

8. AGE: Years 70 | Months 8 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Solomon Wasserman
13. Birthplace Germany

MOTHER
14. Maiden Name Fanny Kaufman
15. Birthplace Baltimore

16 (a) Informant Mr. Jerry Goldsmith, nephew
(b) Address 3317 Forest Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/25/47 (month) (day) (year)
(c) Cemetery or crematory Oheb Shalom
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 APR 24 1947 (b) [illegible] Registrar
(Date filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-23 1947 at 12:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-5 1947 to 4-23 1947 and that I last saw him alive on 4-23 1947.

Immediate cause of death coronary occlusion — Duration

Due to Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert Lundell M. D.
Address 212 Light St. Date signed 4-23-47

VS 150

C51033

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C51033

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3909 Springdale Ave
(c) Hospital or institution: 15-10
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3909 Springdale Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME (Mrs) Annie Silversey

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband ~~or wife~~ Mendel Silversey

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 15-1865

8. AGE: Years 82 | Months 0 | Days 8 | If less than one day hr. — min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation at home

11. Industry or business —

FATHER
12. Name Jacob Savage
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah Rebecca Savage
15. Birthplace Russia

16 (a) Informant Mayer Silversey
(b) Address 3909 Springdale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 25/47 (month) (day) (year)
(c) Cemetery or crematory Arlington Cem.
Location Hamilton Ave, Roadside

18 (a) Funeral director Jos. Leanord & Bro.
(b) Address 1524-26 N. Howard Ave.

19 (a) ~~ADD~~ APR 24 1947 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1947, at 1.50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 9 1947 to Apr 23 1947, and that I last saw h[er] alive on Apr 23 1947.

Immediate cause of death: arteriosclerosis
Coronary thrombosis — Duration

Due to —

Due to —

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Benjamin Kadrr M. D.
Address 2206 Edtaw Pl Date signed 4-24-47

X

VS 150

G51034

BALTIMORE CITY HEALTH DEPARTMENT RHYON ✓

CERTIFICATE OF DEATH 137a

Registered No. G51034

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Sinai Hospital 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City ~~or town~~ Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 621 St. Paul St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Robert Rhyon

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Margaret Rhyon
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 15, 1883

8. AGE: Years	Months	Days	If less than one day
63	11	8	..... hr. ..... min.

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation Clothing Mfgr.
11. Industry or business

FATHER
12. Name Isaac Rhyon
13. Birthplace Russia

MOTHER
14. Maiden Name Leah Jaffee
15. Birthplace Russia

16 (a) Informant Mrs. R. Rhyon
(b) Address 621 St. Paul St.

17 (a) Cremation (b) Date thereof 4/ /47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~crematory~~ Greenmount
Location Balto., Md.

18 (a) Funeral director Harris Lowenstein & Son
(b) Address 1902 Eutaw Place

19 (a) APR 24 1947 (b) Huntington Williams
(Date received by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 April 1947, at 2:40 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/8/1947, to 4/23 1947.
and that I last saw h.i.m. alive on 4/23 1947

Immediate cause of death	Duration
Cerebral embolus	
Due to Sub-acute bacterial endocarditis	
Due to Mitral valvulitis	
Other Conditions Benign Prostatic Hypert. Hypertension Varicose Diverticulum	

(Include pregnancy within 3 months of death)

Date of operation 3/7/47
Major findings of operation: Prostatic Hypert. Varicose Diverticulum
of autopsy: as above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at .....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature Harold M. Gordon M. D.
Address Sinai Hosp. Date signed 4/23/47

G51035

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30E

G51035 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 106 East Chase St
(c) Hospital or institution: D Johnson's Office
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 3
(e) Length of stay in Baltimore (yrs., mos., or days) 67 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3010 Auchentoroly Terrace (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Kaufman Sidney Harry (Sidney H. Kaufman)

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mrs Emma Kaufman
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) July 22 1869

8. AGE: Years	Months	Days	If less than one day: hr.	min.
67	9	1		1879

9. Birthplace Washington DC (Town, county, and state)
10. Usual Occupation Stage Manager
11. Industry or business Theatre

FATHER
12. Name Joseph Kaufman
13. Birthplace Germany

MOTHER
14. Maiden Name Sophie Kaufman
15. Birthplace St Marys Co. Md.

16 (a) Informant Mrs Florence L Hymenadez
(b) Address 3010 Auchentoroly Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/25/47 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director Harris Funeral Home
(b) Address 1824 Eutaw Place

19 (a) APR 24 1947 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 23 1947 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 16 1947 to Apr 23 1947 and that I last saw him alive on Apr 22 1947.

Immediate cause of death Pulmonary Edema — Duration: Years

Due to Aortic Insufficiency

Due to Endo.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J & M Johnson M. D.
Address 106 E Chase St Date signed 4-23-47

G51036

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G51036 Registered No.

1577

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Colo (b) County
(c) City or town Pueblo (If outside city or town limits, write RURAL and give town)
(d) Street No. 1901 Court 21 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel Lewis Strieby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-15-46

8. AGE: Years | Months: 9 | Days: 5 | If less than one day: hr. min.

9. Birthplace Colorado (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Robert Strieby

13. Birthplace Colo.

MOTHER 14. Maiden Name Mary Jane Tartaglia

15. Birthplace Colo.

16 (a) Informant Records.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 26/47 (month) (day) (year)

(c) Cemetery or crematory Roselawn Cemetery

Location Pueblo Colo.

18 (a) Funeral director John O. Mitchell Sons

(b) Address 1900 Eutaw Place

19 (a) APR 24 1947 (Date rec'd by registrar) Huntington-Williams Mem

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1947, at 8 35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 17 1947 to Apr 23 1947 and that I last saw deceased alive on Apr 23 1947.

Immediate cause of death Hypernephroma of

(a) central origin

Cardiac failure

Due to Congenital cerebral defect

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George L Palmer

Address Johns Hopkins Hosp. Date signed 4-23-47

VS 150

correct age is especially important. Physicians: please write the

G51037

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183

Registered No. G51037

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Medbine
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alfred E. Murray

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-10-2056

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Sadie V. Murray
6 (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) Aug. 9, 1911

8. AGE: Years	Months	Days	If less than one day
35 ~~335~~	8	15	hr. min.

9. Birthplace Balto. Co. Maryland
(Town, county, and state)
10. Usual Occupation Truck Driver
11. Industry or business

FATHER
12. Name Charles N. Murray
13. Birthplace Maryland

MOTHER
14. Maiden Name Jennie Wilson
15. Birthplace Maryland

16 (a). Informant Mrs. Sadie V. Murray
(b) Address Woodbine Md.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 4-26-47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Deer Park
Location near Reisterstown Md.

18 (a) Funeral director C. M. Walz
(b) Address Westfield, Md.

19 (a) APR 24 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23, 1947, at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 26/6
(a) Date of injury 4-23-47 at 2 P.M.
(b) Where did injury occur? Halethird Ave + Broening Rd
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial - Public While at work? Yes
(d) Means of injury Fell from steam roller into creek

23. Signature Edward L. Kaye M.D.
Medical Examiner
Date signed 4-24-47

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51038

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G51038

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Dot
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 5d
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County:
(c) City or town: Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No.: 1439 Mulliken Ct (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country:

3 (a) FULL NAME: Lloyd Johnson

3 (b) If veteran, name war: !
3 (c) Social Security Account No: 218-07-0221

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Oct. 1902

8. AGE: Years: 44 | Months: 6 mo | Days: | If less than one day: hr. min.

9. Birthplace: Memphis Tenn. (Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business:

FATHER
12. Name:
13. Birthplace: Tenn

MOTHER
14. Maiden Name:
15. Birthplace: Tenn

16 (a) Informant: Myrtle Johnson
(b) Address: 1439 Mulliken Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: April 24 1947 (month) (day) (year)
(c) Cemetery or crematory: Mt Calvary Cemetery
Location: A A Co. Md

18 (a) Funeral director: Robert E Williams
(b) Address: 1565 McElderry St

19 (a) APR 24 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7/19 1947 at 11:50 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Chronic Myocardial Degeneration

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury: at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury:

23. Signature: E. J. Lubinski M.D. Medical Examiner.
Date signed: 4/20/47

VS 151

Please answer all questions as completely as possible. Physicians: please write the causes of death clearly and legibly.

G51039
CWK-109516

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46 F

G51039
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 Days
(e) Length of stay in Baltimore (yrs., mos., or days) None

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Ridgley 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. No street address
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lawrence Carey Callahan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Geraldine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 28-1893

8. AGE: Years 54 | Months 1 | Days 26 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Callahan
13. Birthplace Maryland

MOTHER
14. Maiden Name Ada Slaughter
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Ridgley
Location Ridgley, Md

18 (a) Funeral director E. L. Lane
(b) Address Church Hill, Md

19 (a) (b) Registrar Huntington Williams M.D.

APR 29 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1947, at 6:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mch. 29 1947, to Apr. 24 1947, and that I last saw him alive on Apr. 24 1947.

Immediate cause of death — Duration

Due to — 2 hrs

Due to — 4 hrs

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lowell A. O'Neill M.D.
Address Balto. City Hosp. Date signed 4/24/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G51040

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

✓ G51040 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address MONUMENT ST
(c) Hospital or institution: SINAI HOSPT 2-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 101 ALBERMARLE ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sam Aaronson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W	W

6 (b) Name of husband or wife RAY
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
72			hr. min.

9. Birthplace ROUMANIA (Town, county, and state)
10. Usual Occupation CABINET MAKER
11. Industry or business

FATHER
12. Name SHIMMEL
13. Birthplace ROUMANIA

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace ROUMANIA

16 (a) Informant HOSPT. RECORDS
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4-24-47 (month) (day) (year)
(c) Cemetery or crematory MT. CARMEL
Location OLD GERMON HILL RD
18 (a) Funeral director JOLK LEWIS INC
(b) Address 1439 E. BOLTO ST.
19 (a) (Date received by registrar) (b) Registrar

APR 24 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23, 1947, at 925 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 23 1947, to Jan. 23 1947, and that I last saw him alive on Jan. 23 1947

Immediate cause of death	Duration
Cardiac failure	
Due to Myocardial infarction	
Coronary occlusion	
Due to Arteriosclerotic heart disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sidney Green M. D.
Address Sinai Hospital Date signed 4/24/47

Huntington Williams, MD

G51041

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V164a

G51041 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Seton Institute 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3518 Greenmount Ave. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Wilbur Cooney

3 (b) If veteran, name war NONE

3 (c) Social Security Account No. 216-07-0976

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ann Harron Cooney

6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) Mar. 20, 1899

8. AGE: Years	Months	Days	If less than one day
48	1	3	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Mechanic

11. Industry or business Martin J. Barry Tire Co.

FATHER
12. Name John Cooney
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Welsh
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Ann Harron Cooney
(b) Address 3518 Greenmount ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/26/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. P. Evans & Son Inc.
(b) Address 118 W. Mt. Royal Ave

APR 24 1947 (Date registered) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1947, at 5:25 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to hanging

Other Conditions Manic Depressive State

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-23-47 at 4:55 P.M.
(b) Where did injury occur? Seton Institute
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? no
(d) Means of injury Hanging by bed-sheet

23. Signature Edward L. Kemp M.D. (Medical Examiner)
Date signed 4-23-47

VS 151

Dr. Allen Beatham
3931 E. Balto St.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G51042
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1908 E. Belvedere
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1908 E. Belvedere Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis William Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Emma V.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 8-1867

8. AGE: Years	Months	Days	If less than one day
79	6	15	hr. min.

9. Birthplace Washington, D.C.
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name William Johnson
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Emma Johnson
(b) Address 2528 Orleans St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-26-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

APR 24 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-23- 1947, at 4:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from MAR 1- 1947 to APR 23 1947, and that I last saw h. alive on April 22 1947.

Immediate cause of death: Cardiac Failure

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Allen C. Beatham M. D.
Address 3134 E. Baltimore Date signed 4-23-

Rec'd X 47

G51043

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 559

G51043
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3324 Cliftmont Ave.
(c) Hospital or institution: 26-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3324 Cliftmont Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME LONGIN F. BREFFKA

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Anna (nee Komenda)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 14, 1881

8. AGE: Years	Months	Days	If less than one day
66 yrs	1	8	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Baker
11. Industry or business

FATHER
12. Name Martin Breffka
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Anna Komenda Breffka
(b) Address 3324 Cliftmont Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/25/47 (month) (day) (year)
(c) Cemetery or ~~dewelery~~ Holy Redeemer
Location 4430 Belair Rd. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) (Signature of registrar) (b) Registrar

4 1947 Huddington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1947, at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1946 to April 22 1947
and that I last saw h.. alive on 19

Immediate cause of death: Cardiac Decompensation
Left Pneumonia

Duration
1 5 mo.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 3400 Eastern Ave Date signed 4/22/47

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51044

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Register No. G51044

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 2-
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1929 Fleet St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie Saunders Merritt

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	M

6 (b) Name of husband or wife Shelby Merritt
6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) 12-14-1907

8. AGE: Years	Months	Days	If less than one day: hr.	min.
45	4	9		401

9. Birthplace W. Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name B. J. Mayers
13. Birthplace Va.

MOTHER
14. Maiden Name Susan Lockhart
15. Birthplace W. Va.

16 (a) Informant Mr. Shelby Merritt
(b) Address 1929 Fleet St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/26/47 (month) (day) (year)
(c) Cemetery or crematory Bushfork Cem
Location Huntington W. Va.

18 (a) Funeral director Weikel & Hoppel
(b) Address 215 E. Highland Ave

19 APR 24 1947 Huntington, W. Va.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22, 1947, at 2 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 22, 1947 to April 22, 1947 and that I last saw h alive on 19

Immediate cause of death Dead on arrival
Cardiac failure

Due to Coronary occlusion - myocardial infarction,

Due to Arterio-sclerotic heart disease.

Other Conditions Chronic cholecystitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Coronary occlusion

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sidney Green M. D.
Address Sinai Hospital Date signed 4/22/47

V S 150

C. J. Lubinski MD per G. G. Merrill MD

G51045

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G51045 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Caton Avenue
(c) Hospital or institution: Jenkins Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 Mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1300 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George M. Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race W White

6 (a) ~~Single~~, married, widowed, ~~or divorced~~ Widower

6 (b) Name of husband or wife Mary Chatard Brown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1871

8. AGE: Years 75 | Months 10 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Retired.

11. Industry or business

FATHER 12. Name V. J. Brown
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Mary Cook
15. Birthplace Baltimore Md.

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/25/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Frederick Ave.

18 (a) Funeral director H. H. Sheas and Son
(b) Address 845 N. Calvert St.

19 (a) APR 24 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1947, at 2:00 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 19, to 19, and that I last saw h alive on 19.

Immediate cause of death	Duration
Cardiac Failure	
Due to Coronary insufficiency, acute	
Due to	
Other Conditions Angina Pectoris	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry W. Wolfe M. D.
Address St. Agnes Hosp. Date signed 4-23-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G51046 Dr Day 4E33rd 10-11 93D G51046

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

1. PLACE OF DEATH: Patient 1790
(a) Baltimore City, Maryland
(b) Street address 1400 W. Lexington St
(c) Hospital or institution:
Aged Women & Aged Men Homes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 W. Lexington St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Clay Bowen

3 (b) If veteran, name war W | 3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 8. 1856

8. AGE: Years	Months	Days	If less than one day
90	6	10	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name George Washington Bowen
13. Birthplace

MOTHER 14. Maiden Name Lucy Ann Van Cradel
15. Birthplace

16 (a) Informant Mrs. Read Left.
(b) Address 1460 N. Lexington St.

17 Cremation (Burial, cremation, or removal) (b) Date thereof 4/25/47 (month, day, year)
(c) Cemetery or crematory Baltimore Md
Location Baltimore Md

18 (a) Funeral director William Cook Inc
(b) Address 1317 St Paul Street

19 APR 24 1947 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1947, at 4:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1st 1947 to April 23 1947 and that I last saw him alive on April 21 1947.

Immediate cause of death	Duration
Cardiac Respiratory Failure	
Acute Coronary occlusion	
Due to Generalized arteriosclerotic	
Cardio-vascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Newland Edward Day M. D.
Address 4-E-33rd St Balto 18 Date signed 4-24-47

G51047 Cr. Marshall Anderson

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G51047

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3028 Harlem Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3028 Harlem Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Adolf G. Fischer

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 212-12-9160

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Married

6 (b) Name of husband or wife: Mildred
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 22,1900

8. AGE: Years	Months	Days	If less than one day
46	5	0	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Maintance Man
11. Industry or business Carr Lowery Glass Co.

FATHER
12. Name Frederick Fischer
13. Birthplace Germany

MOTHER
14. Maiden Name Rose (Unknown)
15. Birthplace Germany

16 (a) Informant Mildred Fischer
(b) Address 3028 Harlem Avenue

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 4/25/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) APR 24 1947 (Date received by City Registrar) Registrar, Huntington Woods, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22, 1947, at 8:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-?-47 19 to 4-22 19 47 and that I last saw h[illegible] alive on 2-18-47 19.

Immediate cause of death: Coronary Thrombosis — Duration Suddenly

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry J. Limbel M. D.
Address 2203 Edmondson Date signed 4-24-47

G51048 Wabash Ave. BALTIMORE CITY HEALTH DEPARTMENT 94a Registered No. G51048

CERTIFICATE OF DEATH

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2016 Robb Street
(c) Hospital or institution: 9-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Street
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2016 Robb Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert M. Coale

3 (b) If veteran, name war: —
3 (c) Social Security Account No. 216-03-0221

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife: Virginia Lee Hare
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 26, 1909

8. AGE: Years	Months	Days	If less than one day
38	2	27 28	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business Sun Cab Company

FATHER
12. Name John Coale
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Helen Emerine
15. Birthplace Baltimore, Maryland

16 (a) Informant Virginia Coale
(b) Address 2016 Robb Street

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 4/26/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) APR 24 1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23, 1947, at 7:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 10 1947, to April 23 1947, and that I last saw h[illegible] alive on April 23 1947.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]
Address 1331 E. Fourth St. Date signed 4-23-47. M.D.

VS 150

G51049 Hunter

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G51049

Form of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 517 Tunbridge Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 517 Tunbridge Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Josephine M. Hunter

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife John J.

6 (c) If living, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 7-1872

8. AGE: Years 74 | Months 7 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Joseph A. Mcgan
13. Birthplace Germany

MOTHER 14. Maiden Name Josephine Jackson
15. Birthplace Balto. Co. Md.

16 (a) Informant Mrs. Hunter
(b) Address 517 Tunbridge Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/26/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Ave

18 (a) Funeral director J. Edward Greenmount
(b) Address

19 (a) APR 24 1947 (Date rec'd by registrar) Lemington for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1947, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 22 APR. 1947, to 22 APR. 1947, and that I last saw her alive on 22 APR. 1947.

Immediate cause of death Coronary Thrombosis — Duration 2 Hrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lloyd E. Saylor M. D.
Address 3902 Greenmount Ave Date signed 23 APR. 47

V S 150

G51050

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registration No. G51050

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Light St
(c) Hospital or institution: So Baltimore Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 9 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 420 Freeman St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Joann) Johann Buchanan DARE A Hile

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 27 (1935)

8. AGE: Years	Months	Days	If less than one day
9 (10)	4	26	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER
12. Name Arnold B. Hoyle Hile
13. Birthplace Va.

MOTHER
14. Maiden Name Margarette Buchanan Buchanan
15. Birthplace Va.

16 (a) Informant Mrs. Carrie Buchanan
(b) Address 2615 Hilton St.

17 (a) Burial (b) Date thereof 4/26/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Monkton Church
Location Monkton, Md.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 Eutaw Pl.

19 (a) [illegible] 1947 (b) Huntington Williams, M.D. Address, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/[illegible]/1947 at 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from DOA 19 to 19, and that I last saw h alive on 19.

Immediate cause of death: Overwhelming Toxemia — Duration

Due to Lobar Pneumonia

Due to RT Lung

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Lobar Pneumonia RT Lung

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature G Brooks Lose Th [illegible] M. D.
Address 1211 Light St. Date signed X 4-24-47

VS 150

505512 G51051

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a

Registered No. G51051

Please write clearly with pen or pencil, using ink of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County St. Marys.
(c) City or town Clements
(If outside city or town limits, write RURAL and give town)
(d) Street No.....
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Mary Estelle Hall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 4-8-17

8. AGE: Years 30 | Months 29 | Days . | 16 | If less than one day ..... hr. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER
12. Name John Hall
13. Birthplace Md.

MOTHER
14. Maiden Name May Malle
15. Birthplace Md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/26/47 (month) (day) (year)
(c) Cemetery or crematory St. Joseph's
Location Emmitsburg, Md.

18 (a) Funeral director U. L. Smith Undertaking Co.
(b) Address Leonardtown, Md. Acting for Williams, Md.

19 (a) ..... Registrar
(Date rec'd by Local Registrar) APR 24 1947

MEDICAL CERTIFICATION

A

20. DATE OF DEATH April 24 1947, 5.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 29 1946, to April 24 1947, and that I last saw her alive on April 24 1947.

Immediate cause of death Carcinomatosis — Duration .....

Due to ..... — Duration .....

Due to Carcinoma of Cervix — Duration .....

Other Conditions Thrombophlebitis — Duration .....

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy: Not Obtained

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature Felix Rutledge M. D.
Address Johns Hopkins Hospital 4/26/47

X

G51052

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 20

G51052 Registered No.

Please write the causes of death clearly and legibly. The correct age is especially important. Physicians: please write all information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkens Ave
(c) Hospital or institution:
St. Agnes Hospital 28
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Seton Institute (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sister Eulalia Collins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Religious

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 20, 1905

8. AGE: Years	Months	Days	If less than one day
41	9	3	hr. min.

9. Birthplace Fair Haven Vermont (Town, county, and state)

10. Usual Occupation Religious

11. Industry or business Supervision

FATHER
12. Name Patrick Collins
13. Birthplace Cape of Good Hope S. Africa

MOTHER
14. Maiden Name Louisa Granger
15. Birthplace Keyville Va.

16 (a) Informant Sister Rosamond
(b) Address 1420 Reisterstown Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-25-47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Seton Institute (Private)
Location Reisterstown Rd - Balto. - Md.

18 (a) Funeral director Stewart & Mowen Company
(b) Address 108 West North Ave. - City - 1

19 (a) (Date rec'd by registrar) Huntington Williams M.D.

APR 24 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/23 1947, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1 1947 to 4/23 1947 and that I last saw her alive on 4/23 1947.

Immediate cause of death	Duration
Uremia	
Due to Kidneys Shut-down. (Ind. of Endometrium)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 4/14-18-20/47

Major findings of operation: Pus Tubes Endometritis and Salpingitis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Williams Smith Jr. M.D.
Address St. Agnes Hosp. Date signed 4/23/47

X

G51053

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1493

G51053 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4 N. Monroe Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4 N. Momroe Street
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME VERA C. LAWRENCE

3 (b) If veteran, name war ********

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife William T.

6 (c) If alive, give age D. years

7. Birth date of deceased (mo., day, yr.) 12-6-1905

8. AGE: Years 41 | Months 4 | Days 15 | If less than one day ********** hr. ********** min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation Treas. & Secty.

11. Industry or business American Rug Cleaning Co

FATHER
12. Name Andrew Soeder
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Ella L. Cortes
15. Birthplace Baltimore Maryland

16 (a) Informant Mrs. Andrew Soeder
(b) Address 4 N. Monroe Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 24 Apr 47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore Maryland

18 (a) Funeral director C. Blessington & Son
(b) Address 1300 Eutaw Place...17

19 APR 24 1947 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 21, 1947 19 , at 1:30 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 19 47 to Apr. 21st 19 47. and that I last saw her alive on Apr. 21, 19 47.

Immediate cause of death MALIGNANCY OF FALLOPIAN TUBE. — Duration 6 mos.

Due to

Due to

Other Conditions.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard S. Thrasher M. D.
Address Baltimore & Payson Sts. Date signed 4-23-47

VS 150

correct age is especially important. Physicians: please write the

51054

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

49a

Registered No. C51054

Consult age is especially important. Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1640 East 32nd Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1732 East 30th Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eva C. Stoffregen

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married

6 (b) Name of husband or wife William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2, 1886

8. AGE: Years	Months	Days	If less than one day
61	1	22	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Nicholas Bishop
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Seeburger
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Louise Hill
(b) Address 1640 East 32nd Street

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 4/28/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

APR 25 1947 (Date filed by registrar) (b) Investigator Williams MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24, 1947, at 7:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1947, to 4-24 1947, and that I last saw her alive on 4-24 1947.

Immediate cause of death	Duration
Generalized Carcinomatosis	6 Mo.
Due to Carcinoma of ovary & Metastasis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Nov. 1946
Major findings of operation: Carcinoma of ovary & Metastasis
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis Vogel Jr. M.D. M. D.
Address 1204 E. 33rd St. Date signed 4-24-47

X

55 1055

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. C51055

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 817 St. Paul St.
(c) Hospital or institution: 11

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 817 St. Paul St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Louis Hougardy

3 (b) If veteran, name war: World 1

3 (c) Social Security Account No. 149-07-6873

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9, 1890

8. AGE: Years	Months	Days	If less than one day
56	11	15	hr. min.

9. Birthplace Jersey City, N.J. (Town, county, and state)
10. Usual Occupation Public Relation Exec.
11. Industry or business

FATHER
12. Name Alexander Hougardy
13. Birthplace Belgium

MOTHER
14. Maiden Name Catherine Farrell
15. Birthplace Jersey City, N.J.

16 (a) Informant Routh Funeral Home
(b) Address Jersey City N.J.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof April 25 1947 (month) (day) (year)
(c) Cemetery or crematory
Location Jersey City, N.J.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves.

19 (a) Filed (Date) APR 25 1947 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from about Nov 1946 to April 24 1947, and that I last saw h alive on about April 24 1947.

Immediate cause of death Coronary occlusion — Duration few minutes

Due to Arteriosclerosis CVD — Duration several years

Due to — Duration

Other Conditions Previous coronary thrombosis — Duration 6 months

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature G. Hughstein M. D.
Address 888 W. Lombard St Date signed 4.24.47

VS 150

Please write the causes of death clearly and legibly. Physicians: please write. Information should be carefully supplied. Correct age is especially important.

551056

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Reg. C551056

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2476 Shirley Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2476 Shirley Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cherna Massing

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Late Simon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1855

8. AGE: Years 92 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Barish Koren
13. Birthplace Russia

MOTHER
14. Maiden Name Mariam ?
15. Birthplace Russia

16 (a) Informant Israel Massing
(b) Address 3734 Towanda Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 25, 1947 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel Road
Location German hill Road

18 (a) Funeral director Sol, Levinson & Bros
(b) Address 1124 1126 W North Ave

19 APR 25 1947 Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24, 1947, at 5.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 1, 1947, to April 24 1947, and that I last saw h[illegible] alive on April 24 1947.

Immediate cause of death Heart Failure

Due to Toxemia

Due to Carcinoma of the Colon

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 8 months

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel Weinstein M.D.

Address 3431 Clark Ave Date signed April 24, 1947

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51057.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G51057.
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1808 Gough St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1808 Gough St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Pawlowicz

3 (b) If veteran, name war
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Jacob
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unk

8. AGE: Years 76 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Joseph Homy
13. Birthplace Poland

MOTHER
14. Maiden Name Tigeio ?
15. Birthplace Poland

16 (a) Informant Tillie Penozek
(b) Address 1808 Gough St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 29/47 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore

18 (a) Funeral director Fred W Ozazynski
(b) Address 1950 Eastern Ave

APR 25 1947 (b) Huntington Williams, M.D.
(Local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1947 at 7.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1, 1947, to April 23 1947, and that I last saw deceased alive on April 23 1947.

Immediate cause of death: Carcinoma of stomach with metastases — Duration: ?
Due to: primary
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Mark Steinglass
Address 1007 E Pratt St Date signed 4-24-47 M.D.

VS 150

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

51058

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 16

G51058
Registered No.

Write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 934 Brevard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Cora May Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	—

6 (b) Name of husband or wife —

6 (c) If live, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 7, 1941

8. AGE: Years	Months	Days	If less than one day
6	3	12	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation child
11. Industry or business

FATHER
12. Name Houston Robinson
13. Birthplace Chesterfield Co. S.C.

MOTHER
14. Maiden Name Camilla Moore
15. Birthplace Hadesboro, N. C.

16 (a) Informant Houston Robinson
(b) Address 934 Brevard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/26/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill, Md.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

APR 25 1947 (a) Registrar (b) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-19- 1947, at 1-05 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Strangulation
Lacerations of anus
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4/19/47 at 12:55 A.M.
(b) Where did injury occur? (Home) Alley - 100 blk Preston St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury manual strangulation

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 4-19-47

G51059

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

G51059 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 700 Fleet St. 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) dea.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: found: Harbor Foot of Lancaster St
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 504 Orchard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country No.

3 (a) FULL NAME Edward Walls

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	married

6 (b) Name of husband or wife Annabelle
6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) Aug. 3, 1907

8. AGE: Years	Months	Days	If less than one day
39	8	18	hr. min.

9. Birthplace Augusta Georgia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Beth. Shipyard

FATHER
12. Name Edward Walls
13. Birthplace Georgia

MOTHER
14. Maiden Name Mary Thomas
15. Birthplace Georgia

16 (a) Informant Annabelle Walls
(b) Address 2039 Pennsylvania Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/24/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill, Md.

18 (a) Funeral director A. Halstead
(b) Address 916 Druid Hill Ave.

APR 25 1947 (Date received by registrar) Huntington Williams M.D. (Local registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-21st 1947, at 3P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-21-47 at ? 2/3 M.
(b) Where did injury occur? Harbor; Foot of Lancaster St
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Found drowned.

23. Signature Earl L. Royer M.D. Medical Examiner.
Date signed 4-22-47

X

G51060

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G51060

bk# b-68233 SIMMS 157E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 687 W. Mulberry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Otis Simms

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M.

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-13-47

8. AGE: Years | Months: 3 | Days: 10 | If less than one day: hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Otis Bailey
13. Birthplace Md.

MOTHER
14. Maiden Name Alverta Simms
15. Birthplace Md.

16 (a) Informant Alverta Simms
(b) Address 687 W. Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-26-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location Cedar Hill, Md.

18 (a) Funeral director Adolphus Stallard
(b) Address 918 Harriet Hill Ave.

19 (a) APR 25 1947 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-23 1947, at 5:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-23 1947, to 4-23 1947 and that I last saw h/ke alive on 4-23 1947.

Immediate cause of death: Atelectasis — Duration

Due to: Bronchopneumonia

Due to:

Other Conditions: Patent ductus arteriosis, interventricular septal defect.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: 4-24-47 Facts as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gerald A. Martin M. D.
Address Univ. Hospital Date signed 4-24-47

107

51061
AB-109786

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1947

Registered No. G51061

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10days
(e) Length of stay in Baltimore (yrs., mos., or days) 20yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 615 Pierce Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Robinson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Separated

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb. 22- 1880

8. AGE: Years	Months	Days	If less than one day
67	1	28	hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation D.P.W.
11. Industry or business

FATHER
12. Name Samuel Robinson (D
13. Birthplace Va.

MOTHER
14. Maiden Name Elizabeth Burnham (D
15. Birthplace Va.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 4/30/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill, Md.

18 (a) Funeral director A. Stalfort
(b) Address 918 Druid Hill Ave.

APR 25 1947
(Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20- 1947, at 4.45PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-10- 1947, to 4-20- 1947, and that I last saw h im alive on 4-20- 1947.

Immediate cause of death Respiratory Failure — Duration Unknown

Due to

Due to Arteriosclerotic C.V.D. Congestive Failure

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edmund Beacham
Address Balto City Hosp Date signed 24 Apr 47 M. D.

51062

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G51062 Registered No. 131a

Correct age is especially important. Physicians: please write the cause of death clearly and legibly. Use ink. Do not abbreviate or use ditto marks. If unknown, state so. Do not carelessly supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 308 Washburn Ave
(c) Hospital or institution: -

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 4
(e) Length of stay in Baltimore (yrs., mos., or days) /

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 308 WASHBURN AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William F. Gabrio

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-05-9589

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: Frieda Gabrio
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) 11/21/(1877)

8. AGE: Years 69 (70) | Months 5 | Days 1 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Butcher

11. Industry or business

FATHER 12. Name William Gabrio
13. Birthplace Germany

MOTHER 14. Maiden Name Marie Heck
15. Birthplace Baltimore

16 (a) Informant Frieda Gabrio
(b) Address 308 Washburn Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/25/47 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Edmondson Ave

18 (a) Funeral director Charles F. Hill
(b) Address 1501 E. Fort Ave.

(Date received) April 23 1947 (Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1947, at 8 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 2 1947, to April 22 1947, and that I last saw h-- alive on April 21 1947.

	Duration
Immediate cause of death 1877 Coronary Occlusion	30 Min.
Due to Arteria Sclerosis	20 d.
Hypertension	20 d.
Due to Mitral Regurgitation	20 d.
Other Conditions Chr. Interstitial Nephritis	20 d.

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury F.F.A. Storms
23. Signature M. D.
Address 2878 Harford Rd Date signed 4-24-47

VS 180

92 B

51063

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G51063 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write as carefully as possible. Every item is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1001 Broadway
(c) Hospital or institution: Church Home & Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 111 N Caren St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs Nellie F. Morton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed.

6 (b) Name of husband or wife Chas. Morton
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr) ?

8. AGE: Years 26 yrs? | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Retired

FATHER
12. Name Walter Fernandis
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary E. Griffith
15. Birthplace Baltimore

16 (a) Informant (Sister) Isabelle Fernandis
(b) Address 111 N Caren St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 26/47 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Greenmount Ave. & Oliver St

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1410 Eutaw Place

APR 25 1947 Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27, 1947, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 24 1947 to Apr 24 1947 and that I last saw h alive on Apr 24 1947.

	Duration
Immediate cause of death Bronchopneumonia	3 days.
Due to Arteriosclerosis general	20 yrs.
Due to Arteriosclerotic heart disease	20 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. **Signature** David Bachrach M. D.
Address Church Home & Hosp Date signed Apr 24 47

VS 150

51064

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

Registered No. G51064

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1711 Brices Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1711 Brices Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Gardner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 24, 1894

8. AGE: Years	Months	Days	If less than one day
52	3	29	hr. min.

9. Birthplace King Williams County Va (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER 12. Name Bill Gardner
13. Birthplace King Williams Co Va

MOTHER 14. Maiden Name Dunkum
15. Birthplace King Williams Co Va

16 (a) Informant Annie B. Green (Cousin)
(b) Address 328 Mount Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 25, 1947 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn
Location Baltimore City

18 (a) Funeral director Joseph A. Leidy
(b) Address 601 West Baltimore St.

APR 25 1947 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22, 1947 at 10 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Volvulus of intestine, with intestinal obstruction,
Due to gangrene of intestine, and peritonitis.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 4/22/47

G51065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G51065 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write necessary supplies.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2317 Etting St.
(c) Hospital or institution: 147
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2317 Etting St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Georgieanna Waters Frey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1880

8. AGE: Years 66 67 | Months 10 | Days 6 | If less than one day hr. min.

9. Birthplace Randallstown, Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name James Waters
13. Birthplace Randallstown, Md.

MOTHER
14. Maiden Name Fannie Minikin
15. Birthplace Randallstown, Md.

16 (a) Informant Mrs. Bessie Hart
(b) Address 5302 Wenmore Ave.

17 (a) Burial (b) Date thereof Apr. 25, 1937
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory M. Thomas
Location Randallstown, Md.

18 (a) Funeral director Mrs. George A. Hulland
(b) Address 1631 Druid Hill Ave

19 (a) APR 25 1937 (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 22 1937, at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 22 1937, to Apr 22 1937, and that I last saw h[illegible] alive on Apr 2x 19x7.

Immediate cause of death Chronic Valvular Heart Disease — Duration 2 years

Due to Cerebral Hemorrhage — Duration 5 days

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ernest Lamar Frey M. D.

Address 1928 Penna Ave Date signed 4/25/37

VS 150

51066

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G51066
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1503 Madison Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Catherine Brooks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Negro	Widow

6 (b) Name of husband or wife William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 17, 1874

8. AGE: Years	Months	Days	If less than one day
72 73	5	5	hr. min.

9. Birthplace Bel Air, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Rev. Joshua Barnes
13. Birthplace Maryland

MOTHER
14. Maiden Name Martha Rupp
15. Birthplace Bel Air, Md.

16 (a) Informant Mrs. Harry L. Brooks
(b) Address 415 Oxford St.

17 (a) Burial (b) Date thereof April 25, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location Baltimore, Md.

18 (a) Funeral director Mrs. George W. Hallam
(b) Address 1631 Druid Hill Ave.

APR 25 1947 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22, 1947, at 4 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 4 1947, to April 22 1947, and that I last saw her alive on April 22 1947.

Immediate cause of death	Duration
Hypertensive Cardio-vascular Renal Disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George W. Donald M. D.
Address 84 N. Carey St Date signed 4-25-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

51067 TN.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 4/13/47

Registered No. G51067

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1101 Washington Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles M. Beal

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Gertrude
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 19 1899?

8. AGE: Years 47 ? | Months 7 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Laundry Driver

11. Industry or business

FATHER 12. Name Henry
13. Birthplace Md

MOTHER 14. Maiden Name Elizabeth McCubbin
15. Birthplace Md

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/26/47 (month) (day) (year)
(c) Cemetery or crematory New Cadoral
Location Frederick Rd

18 (a) Funeral director Edward Foulkrod
(b) Address 2359 Washington Blvd

APR 25 1947 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION P M

20. DATE OF DEATH April 23rd/1947, at 4.20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dead on Arrival, and that I last saw h alive on 19

Immediate cause of death Pulmonary Tuberculosis, Far-Advanced — Duration Unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Not Done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Hunt M. D.
Address Baltimore City Hosp. Date signed 4-24-47

For Medical Examiner's Approval Earl L. Rose M.D.

Cause of death must be certified clearly and legibly. Physicians: please write the causes of death as directed. Space is especially important. Use typewriter supplied.

51068 JL - 106206

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V/117a

G51068 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 - 1
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 624 W. Fairmount Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Divetary

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: C
6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5 1894.

8. AGE: Years 52 53 ? | Months ? 11 | Days ? 15 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Frank Divetary
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Rachel Queen
15. Birthplace Canada

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 25 1947 (month) (day) (year)
(c) Cemetery or crematory Int. Fairview
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

APR 25 1947 (b) Name rec'd by registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

AM

20. DATE OF DEATH April 20, 1947 19 , at 12:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 19 19 46 to April 20 19 47, and that I last saw him alive on April 20 19 47.

	Duration
Immediate cause of death Respiratory Failure	—
Due to Bronchopneumonia	2 days
Due to	
Other Conditions Hypertensive C.V.D. Hemiplegia, Left. (Include pregnancy within 3 months of death)	—
Date of operation	
Major findings of operation:	
of autopsy: Bronchopneumonia Acute hypertensive gastric ulcer + gastritis	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Elmer Beadenkopf M. D.
Address Baltimore Md Date signed 26 Apr 47

107

51069

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 6

G51069 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 35 days
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No. 200 Penna Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Samuel Reese

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 11-9-46

8. AGE: Years | Months 5 | Days 15 | If less than one day — hr. — min.

9. Birthplace Penna.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Sterling Reese
13. Birthplace Carroll Co

MOTHER
14. Maiden Name Esther E. ?
15. Birthplace Pleasant Co

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof April 27-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bauer
Location Carroll Co.

18 (a) Funeral director H. Bankard & Son
(b) Address Westminster Md.

19 (a) APR 25 1941 (b) Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-24- 1947, at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-19- 1947, to 4-24- 1947, and that I last saw h[illegible] alive on 4-24- 1947.

Immediate cause of death	Duration
Meningococcal meningitis, chronic	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. Rosenzweig M. D.
Address J. H. H. Date signed 4/24/47

VS 150

X

Please write the causes of death clearly and legibly. Physicians: please write age in expressions important. Use necessary supplies.

51070

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G51070 Registered No.

Please answer all questions in full. Space must be completely supplied. Where exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 715 S. Milton Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 715 S. Milton Avenue (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MICHAEL LOUIS SZCZEPANIAK (Steveson)

3 (b) If veteran, name war	3 (c) Social Security Account No.
---	212-05-8052

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Antoinette
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) September 22, 1894

8. AGE: Years	Months	Days	If less than one day
52	7	1	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Production Manager
11. Industry or business Soft Drink Mfr

FATHER
12. Name Franciszek Szczepaniak
13. Birthplace Poland

MOTHER
14. Maiden Name Maryanna Bandoch
15. Birthplace Poland

16 (a) Informant Mrs. Antoinette Szczepaniak
(b) Address 715 S. Milton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/26/47 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Road

18 (a) Funeral director M. J. Sadowski & Son
(b) Address 1808 Eastern Avenue

APR 25 1947 (Date rec'd by Local Registrar) Livingston Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1947, at 9:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 21 1947, to April 23 1947, and that I last saw him alive on April 23 1947.

Immediate cause of death Carcinoma bile ducts — Duration 6 months?
Due to
Due to
Other Conditions.
(Include pregnancy within 3 months of death)
Date of operation Oct. 1946
Major findings of operation: Carcinoma bile ducts
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Seymund R. Nowak M. D.
Address 408 S Patt. Ob. Ac. Date signed 4-25-47

VS 150

X

C51071

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12/a

Registered No. C51071

Please write the causes of death clearly and legibly. Physicians: please write plainly. Any illegible certificate will be returned for completion.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3021 Chesley Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3021 Chesley Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Margaret L. Laragy
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 29-1870

8. AGE: Years	Months	Days	If less than one day
76	3	26	hr. min.

9. Birthplace Balto- Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name William J. Laragy
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Keenan
15. Birthplace Md.

16 (a) Informant Mrs. Walter Norton
(b) Address 3021 Chesley Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-28-47 (month) (day) (year)
(c) Cemetery or crematory Mem. Cathedral
Location Balto.

18 (a) Funeral director Leopold J. Luck
(b) Address 5346 Harford Rd.

19 (a) APR 25 1947 (Date rec'd by registrar) (b) Registrar for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1947 at 8:00 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 10, 1947 to April 24 1947 and that I last saw h.. alive on April 24 1947

Immediate cause of death	Duration
Myocardial Insufficiency	?
Due to Chronic Nephritis	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan Janney M.D.
M. D.
Address 7101 Harford Rd. Date signed 4-24-47

V S 150

G51072

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G51072

Please write the causes of death clearly and legibly. Use only permanent unfading ink. Typewriter supplies. Physicians: please write plainly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1615 Mulberry Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) b
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1615 Mulberry Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George House

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ida House

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12 6 82

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace North Hampton Va
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Eliza
15. Birthplace Va.

16 (a) Informant Ida House
(b) Address 1615 Mulberry Court

17 (a) Burial (b) Date thereof 4/25/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Arlington Mem. Pk
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantly Ave

19 (a) APR 25 1947 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/20/47 19 at 5 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/20 19 47 to 4/20 19 47 and that I last saw him alive on 4/20 19 47.

Immediate cause of death: Pulmonary Edema — Duration 1 day

Due to: Cardio-Renal-Vasculardisease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 1400 W Cadwell Date signed 4/21/47

X

G51073

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G51073

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 808 W Lexington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 808 W Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Georgie Cloud

3 (b) If veteran; name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1903

8. AGE: Years 44 | Months | Days | If less than one day hr. min.

9. Birthplace S. C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Thomas Jackson
13. Birthplace S. C.

MOTHER 14. Maiden Name Mary Smith
15. Birthplace S. C.

16 (a) Informant David Jackson
(b) Address 808 W Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/25/47 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location A. B. Co. Md

18 (a) Funeral director Isaac L. Brown Son
(b) Address 830 W Montgomery St

19 (a) APR 25 1947 (Date rec'd by Registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28 19 47, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-1-1947 to 4-21-1947 and that I last saw h[er] alive on 4-20-1947

Immediate cause of death Cerebral hemorrhage — Duration 3 days

Due to Arterio Sclerosis — 16 mos.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John E. I. Campbell M. D.
Address 603 N. Carey Date signed 4-24-47

VS 190

the causes of death clearly and legibly.

G51074

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G51074

Please write the causes of death clearly and legibly. Physicians: please write as especially important. Please answer all questions as carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2739 Almeda Blvd.
(c) Hospital or institution: [illegible]
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2739 Almeda Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose A. Cassidy

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	S.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-26-1882

8. AGE: Years	Months	Days	If less than one day
64	3	27	hr. min.

9. Birthplace Balt.
(Town, county, and state)
10. Usual Occupation Ret. Schoolteacher
11. Industry or business

FATHER	12. Name James Ireland
	13. Birthplace Ireland
MOTHER	14. Maiden Name Rose Fox
	15. Birthplace Ireland

16 (a) Informant Family
(b) Address 2739 Almeda Blvd.
17 (a) B. (Burial, cremation, or removal) (b) Date thereof 5-26-47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Treadwell Lane.
18 (a) Funeral director L. McCully
(b) Address 1625 E. Fort Ave.
19 (a) APR 25 1947 (Date received by registrar) (b) Huntington Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1947 at 3 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from April 17 1947 to April 23 1947
and that I last saw [illegible] alive on April 22 1947

Immediate cause of death	Duration
Myocardial Insufficiency	
Due to	
Due to	
Other Conditions Arteriosclerosis. Hypertension - Nephritis	

(Include pregnancy within three months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature John A. Scheuerman M. D.
Address 1337 S. Charles St. Date signed 4/25/47

G51075

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1210

Registered No. G51075

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 569 Presstman St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 569 Presstman (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARY PECK

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Widowed

6 (b) Name of husband or wife Jerry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/18/1861

8. AGE: Years	Months	Days	If less than one day
85	11	27 4	hr. min.

9. Birthplace Carroll Co. Md. (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Harry Brown
13. Birthplace Carroll Co. Md

MOTHER
14. Maiden Name Jamins
15. Birthplace Carroll Co. Md.

16 (a) Informant Margaret Bacon (GD)
(b) Address 569 Presstman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/25/47 (month) (day) (year)
(c) Cemetery or crematory Ft. Auburn Cemetery
Location Baltimore, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 Carrollton Ave

19 (a) Filed APR 25 1947 (b) Signature of Registrar Thurston Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/22/47 19 , at 4.00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1/46 1946 to 4-22 1947 and that I last saw h alive on 4-22 1947

Immediate cause of death

	Duration
Cardio-Renal	
Due to	
Due to	57 Mo
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature B. J. Fletcher M. D.
Address 1728 Pa. Ave. Date signed 4/24/47

X

G51076

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X ✓ 33B

Registered No. G51076

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Severn
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

✓

3 (a) FULL NAME David H. Parker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1947

8. AGE: Years | Months: 3 | Days | If less than one day ..... hr. ..... min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Arthur Parker

13. Birthplace md

MOTHER 14. Maiden Name Mamie Galloway

15. Birthplace md

16 (a) Informant Arthur Parker

(b) Address Severn. md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 27-47 (month) (day) (year)

(c) Cemetery or crematory Saints Rest

Location A. A. Co. Md

18 (a) Funeral director James A Hayes

(b) Address 1642 W North Ave

19 (a) APR 25 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1947, at 6 20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-14 1947, to 4-23 1947, and that I last saw h[illegible] alive on 4-23 1947.

Immediate cause of death	Duration
Toxemia	
Due to Meningitis	
Due to H. influenza and D. pneumoniae Type ?	
Other Conditions Spinal fluid block.	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy none.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gerald A. Martin M.D.
Address University Hospital Date signed 4-24-47

VS 150

X

G510777

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G510777

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1136 W. Lexington
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1136 W. Lexington
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kate Hill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Robert Hill

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-3-1876

8. AGE: Years 70 | Months 2 | Days 21 | If less than one day hr. min.

9. Birthplace Ashland, Va
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name George Lewis
13. Birthplace Va

MOTHER
14. Maiden Name Elizabeth Winston
15. Birthplace Va

16 (a) Informant Elizabeth Mason
(b) Address 1136 W. Lexington

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 29-47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director James A Hays
(b) Address 42 W Saratoga St

19 (a) Apr 25 1947 (Only one daily registrar) (b) Washington Ave, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 24 1947, at 1:30 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1947 to Apr 24 1947 and that I last saw h[illegible] alive on April 23 1947.

Immediate cause of death: Hypertension Cardio-vascular disease — Duration: ?

Due to: Hypertension

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert Moseley M.D.

Address 20 W Madison Date signed 4/25/47

VS 150

Moseley X

G5 1078

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G5 1078

Registered No. 157E

BC# B76806

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1574 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 412 South Paca Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Theodore Prince Young

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/21/47

8. AGE: Years | Months | Days: 3 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Prince Young
13. Birthplace Chester, South Carolina

MOTHER
14. Maiden Name Florida Nelson
15. Birthplace Camden, South Carolina

16 (a) Informant Prince Young
(b) Address 412 South Paca St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 25/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Joseph L Russ
(b) Address 120 [illegible] Castle st.

19 (a) APR 25 1947 (Date received by registrar) Huntingtown Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1947, at 5 14/60 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 23 1947, to April 24 1947, and that I last saw him alive on April 23 1947

Immediate cause of death: Congenital Heart Disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Patent Foramen Ovale, Enlarged Thymus

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jerome C. Smith M. D.
Address Provident Hospital Date signed 4-26-47

Specially important. Physicians: please write the causes of death clearly and legibly.

G51079

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

935

Registered No. G51079

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 138 W. Ostend St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 138 W. Ostend St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN WESLEY LIVINGSTON

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widower

6 (b) Name of husband or wife Amelia Livingston
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14, 1878

8. AGE: Years	Months	Days	If less than one day
68	7	9	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Caulker
11. Industry or business Arundel Corp.

FATHER
12. Name Constant Livingston
13. Birthplace Md.

MOTHER
14. Maiden Name Ellen Butler
15. Birthplace Washington, D. C.

16 (a) Informant Mr. Howard Livingston, son
(b) Address 763 Carroll St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/26/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) APR 25 1947 (Filed by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 23, 1947, at 4:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 17 1947, to April 23 1947, and that I last saw him alive on April 22 1947.

Immediate cause of death: Cerebral apoplexy.

Duration

Due to

Due to

Other conditions: Arteriosclerosis; hypertension - myocarditis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John A. Lehmuth, M. D.
Address 1337 S. Charles St. Date signed 4/25/47

VS 150

830

G51080 Grave #5 G51080

BALTIMORE CITY HEALTH DEPARTMENT 183 Registered No.

CERTIFICATE OF DEATH

Found drowned at the foot of Fell St.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street
(c) Hospital or institution:
2-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DEACEASED:
(a) State U Found Ft. of (b) County
(c) City or town N Fell N St
(If outside city or town limits, write RURAL and give town)
(d) Street No. N N (If rural give location)
(e) Citizen of foreign country? O (Yes or No)
If yes, name country W

3 (a) FULL NAME UNKNOWN

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
50 (?)			hr. min.

9. Birthplace U N (Town, county, and state)
10. Usual Occupation K
11. Industry or business N

FATHER	12. Name	O U
	13. Birthplace	W N
MOTHER	14. Maiden Name	N K
	15. Birthplace	U O

16 (a) Informant N W
(b) Address K N
NOWN

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY APR 24 1947

18 (a) Funeral director [illegible] Board of Health
(b) Address

APR 25 1947 [illegible] Williams M.D. Registrar
(Date rec'd by registrar)

VS 181

MEDICAL CERTIFICATION A

20. DATE OF DEATH April 15 1947, at 10:15 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☒ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Drowning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-15-47(?) ? M.
(b) Where did injury occur? Found: Ft. of Fell St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public place While at work?
(d) Means of injury Found drowned

23. Signature [signature] M.D.
Medical Examiner.
Date signed 4-15-47

G51081

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

G51081
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calhoun and Fayette
(c) Hospital or institution:
Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 205 Rosewood Ave. (If rural give location)
(e) Citizen of foreign country? this (Yes or No)
If yes, name country

3 (a) FULL NAME Claire H Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Hattie Thompson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11, 1887

8. AGE: Years	Months	Days	If less than one day
59 60	2 9	18 13	hr. min.

9. Birthplace Mich.
(Town, county, and state)
10. Usual Occupation Teacher
11. Industry or business

FATHER
12. Name James Thompson
13. Birthplace Mich

MOTHER
14. Maiden Name Shora Haysmor
15. Birthplace Mich.

16 (a) Informant Hattie Thompson
(b) Address 205 Rosewood Ave # 24 Catonsville

17 (a) (Burial, cremation, or removal) (b) Date thereof Apr. 27-47 (month) (day) (year)
(c) Cemetery or crematory Pleasant View M. G.
Location Gwynn Falls, Co. Md.
18 (a) Funeral director George A. Kuhlmann
(b) Address Reisterstown, Md.
19 (Signature) for Williams, M.F.

APR 25 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1947, at 7½ M
21. I certify that death occurred on the date above stated; that I attended deceased from April 22 1947, to April 24 1947, and that I last saw him alive on April 24 1947.

Immediate cause of death	Duration
Acute coronary occlusion	3 days
Due to Arteriosclerotic heart disease	7 mos.
Due to	
Other Conditions Diabetes Mellitus	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Stanley B. Klyanowa M. D.
Address Frank. Sq. Hosp. Date signed 4-24-47

VS 150

931

G51082

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G51082

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 238 North High Street
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Charles SAUNDERS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1909

8. AGE: Years 38 | Months | Days | If less than one day .....hr. .....min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Unknown

11. Industry or business

FATHER
12. Name Unknown

13. Birthplace

MOTHER
14. Maiden Name Unknown

15. Birthplace

16 (a) Informant.....
(b) Address

17 (a).....(Burial, cremation, or removal) (b) Date thereof.....(month) (day) (year)

(c) Cemetery or crematory.....
Location University Medical School APR 25 1947

18 (a) Funeral director.....
(b) Address.....

APR 25 1947 (Date received by Registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3, 1947, at 3:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar pneumonia

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature George E. Merrill M.D.
Medical Examiner.
Date signed 4/4/47

651083

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163 H

Registered No. 651083

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 800 Mace St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Harriet J. Hockenfuss

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Francis Wm. Hockenfuss

6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) 12/16/1900

8. AGE: Years	Months	Days	If less than one day
46	4	7	....hr. ....min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Theodore Keller
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Klein
15. Birthplace Maryland

16 (a) Informant Francis Wm Hockenfuss
(b) Address 800 Mace St E. Essex Md

17 (a) Burial (b) Date thereof 4/26/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St Cecils
Location Pikesville - Md

18 (a) Funeral director F. O. Wappert - Inc
(b) Address W. Baltimore St

19 APR 25 1947 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23rd 1947, at 5:35 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Asphyxiation
due to illuminating gas.

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4/23/47 at 5 P. M.
(b) Where did injury occur? 800 Mace St. Essex
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury? Fell Turning of Kitchen range open jet

23. Signature Earl L. Gruber M.D.
Medical Examiner.
Date signed 4-24-47

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65084

65084

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 72 days
(e) Length of stay in Baltimore (yrs., mos., or days) 72 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla. (b) County
(c) City or town Miami
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1837 NW 38th St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mooney, Mark

3 (b) If veteran, name war

3 (c) Social Security Account No. 267-05-9036

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife ?
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Oct. 29, 1879

8. AGE: Years	Months	Days	If less than one day
67	5	27	hr. min.

9. Birthplace New Canaan, Conn.
(Town, county, and state)
10. Usual Occupation Seaman
11. Industry or business Seafarer

FATHER
12. Name Thomas Mooney
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen O'Brien
15. Birthplace Ireland

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Removal (b) Date thereof 12-25-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Canaan - Conn
Location Conn.
18 (a) Funeral director Chas A. Wolberts Funeral Home
(b) Address 403-E-24th St.
19 APR 25 1947 (b) Funeral Director for Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 25 1947, at 7:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 25 1947 to Apr. 25 1947 and that I last saw h im alive on Apr. 25 1947

Immediate cause of death: Squamous cell carcinoma glosso epiglottic fold. — Duration: MORE THAN 6 mos.

Due to

Due to

Other Conditions Pneumonia, lobular right upper lobe — More than 2 wks.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. T. Moore, Jr. USA Surgeon
US Marine Hospital
Address Date signed 4/25/47

VS 150

G51085

GM 108960

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

65 B Registered No. G51085

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitels
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 18
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1756 Darley Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ziegler Ronald

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 8 1940

8. AGE: Years	Months	Days	If less than one day
6	8	16	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name David Elton Ziegler

13. Birthplace Penna.

MOTHER 14. Maiden Name Margregret Brandt.

15. Birthplace Md.

16 (a) Informant Records Baltimore City Hospitals

(b) Address 4940 Eastern Av.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 28-47 (month) (day) (year)

(c) Cemetery or crematory Maryland Park

Location Parkville Md.

18 (a) Funeral director Wm. Cook Inc

(b) Address 217 St Paul Street

19 (a) APR 26 1947 (b) by Thurlington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25- 1947, at 3. 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 7 1947, to April 25 1947, and that I last saw h im alive on April 25 1947.

Immediate cause of death	Duration
Waterhouse - Friderichsen Syndrome	8 hrs.
Due to Empipelas	1 da.
Due to Nephrotic Syndrome	3 mos.
Other Conditions	over

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Wilson E. Hughes M. D.

Address Balto City Hosp. Date signed Apr 25 (47)

X

G51086

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G51086 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1631 E. 32nd Street.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1631- E. 32nd Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AMY BLANCHE HARE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, ~~married, widowed, or divorced.~~ Single

6 (b) Name of husband or wife

6 (c) If alive, give age ~~—~~ years

7. Birth date of deceased (mo., day, yr.) Dec 9th 1869

8. AGE: Years	Months	Days	If less than one day
77	4	16	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER
12. Name John R. Hare
13. Birthplace Birmingham England

MOTHER
14. Maiden Name Mary McConnekin
15. Birthplace Balto. Md.

16 (a) Informant Miss Minnie E. Hare
(b) Address 1631 E. 32nd St.

17 (a) Burial (b) Date thereof 4/28/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 APR 26 1947 (b) Huntington Williams M.D.
(Date rec'd by Local Reg.) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25, 1947, at 4.40 a M

21. I certify that I took charge of the remains described above, held an insp. & inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl V. Ryan M.D.
Medical Examiner

Date signed 4-25-47

G51087

CWK-106214

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G51087

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution:

Baltimore City Hospitals 26 49

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5- 5-

(e) Length of stay in Baltimore (yrs., mos., or days) 40 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 408 S. Eaton Street
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Edward Luther Stonesifer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Separated

6 (b) Name of husband or wife Clara or Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) September 7-1876

8. AGE: Years	Months	Days	If less than one day
70	7	17	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Landscape

FATHER

12. Name Joseph Stonesifer

13. Birthplace Maryland

MOTHER

14. Maiden Name Mary Harris

15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals

(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 4/28/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Oak Lawn

Location Eastern Ave. Extended

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul St.

19 APR 26 1947 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1947, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 19 1946, to Apr. 24 1947, and that I last saw h im alive on Apr. 24 1947.

Immediate cause of death	Duration
Myocardial Infarction, Ventricular Fibrillation.	1mn.
Due to Arteriosclerotic C.V.D.	—
Due to	
Other Conditions Emphysema.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Myocardial Infarction

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Edmund B. Beacham M. D.

Address Baltimore At Hosp Date signed 28 Apr 47

VS 150

X

G51088 B#376613 **BALTIMORE CITY HEALTH DEPARTMENT** **CERTIFICATE OF DEATH** 160c Registered No. G51088

Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 206 E 22nd St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Combs

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 24. 1947

8. AGE: Years	Months	Days	If less than one day
			2 hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Marshall G. Combs
13. Birthplace Ashland Ky.

MOTHER
14. Maiden Name Ruth Edmonston
15. Birthplace Fayetteville N.C.

16 (a) Informant Marshall G Combs
(b) Address 206 E 22nd St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/26/47 (month) (day) (year)
(c) Cemetery or crematory Ashland
Location Ashland Ky

18 (a) Funeral director Fulton & Son
(b) Address 217 E Fayette St

19 APR 26 1947 (Date rec'd by registrar) Washington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/25 19 47 at 8:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death	Duration
Pregnancy	
Due to Separation Placenta	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Samuel Martin M.D.
Address Sinai Hospital Date signed 4/25/47

V S 150

C51089

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

Registered No. C51089

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 819 Hanover Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LEE ERNEST ROBINSON

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1923

8. AGE: Years	Months	Days	If less than one day
24			hr. min.

9. Birthplace Manning S.C.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Gas Station

FATHER
12. Name Sikein Robinson
13. Birthplace S.C.

MOTHER
14. Maiden Name Florence Calhoun
15. Birthplace S.C.

16 (a) Informant Jessie Robinson
(b) Address 819 Hanover St)B)

17 (a) Removal (b) Date thereof 4/26/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Kings Tree
Location South Carolina

18 (a) Funeral director Isaiah L Brown & Son
(b) Address 108 W. Montgomery Street

19 APR 26 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24, 1947, at 10.29 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab-wound of heart.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-24-47 at about 10 p. M.
(b) Where did injury occur? outside Hanover & Montgomery St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Sharp instrument

23. Signature George G. Morrill M.D.
Medical Examiner.
Date signed 4-25-47

VS 181

G51090

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G51090

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2272 Druid Park Drive
(c) Hospital or institution:

13

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2272 Druid Park Drive.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME LEON WHITEHILL.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna K. Whitehill.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch. 23, 1876.

8. AGE: Years 71 | Months 1 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired Stock Clerk.

11. Industry or business

FATHER
12. Name Israel Whitehill,
13. Birthplace Germany.

MOTHER
14. Maiden Name Rachel Mandelbaum,
15. Birthplace Germany.

16 (a) Informant Mrs. Anna K. Whitehill,
(b) Address 2272 Druid Park Drive.

17 (a) Burial (b) Date thereof 4/27/47.
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore Hebrew
Location Balto. Md.

18 (a) Funeral director Harris Sonneborn &
(b) Eutaw Place.

19 (a) APR 26 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24th. 1947 at P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 8 1946 to April 24 1947. and that I last saw him alive on April 24 1947.

Immediate cause of death
Coronary embolism
Due to Generalized arteriosclerosis, Myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Kurt Levy M. D.
Address 2301 Eutaw Place Date signed

VS 150

G51091

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52 B

Registered No. G51091

Type or print the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2304 Harlem Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2304 Harlem Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA V. WEAVER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Wm. E. Weaver
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11, 1873

8. AGE: Years	Months	Days	If less than one day
73	11	12	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Cornelius Brown
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name -
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Margaret I. Margehann
(b) Address 2304 Harlem Ave. 16

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/29/47 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 APR 26 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

APR 26 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23, 1947, at 10:58 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-V-1946 to 4/23 1947 and that I last saw her alive on 4/23 1947.

Immediate cause of death	Duration
Exhaustion	3 Days
Due to Carcinoma of Bladder	7 mths
Due to Cause unknown	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Amelia E. Link M. D.
Address 2211 E. Lake ave Date signed 4/24/47

X

G51092

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓ 83a

Registered No. G51092

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution:
St. Joseph's Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1327 E. North Avenue
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME WALTER Stanley SZYMUSIAK

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Lillian C. Szymusiak
6 (c) If alive, give age, ... years

7. Birth date of deceased (mo., day, yr.) Aug. 21, 1908

8. AGE: Years	Months	Days	If less than one day
38	8	4	..... hr. ..... min.

9. Birthplace Altoona, Pa.
(Town, county, and state)
10. Usual Occupation Mechanic
11. Industry or business Christy Motors

FATHER
12. Name John Szymusiak
13. Birthplace Poland

MOTHER
14. Maiden Name ?
15. Birthplace Poland

16 (a) Informant Mrs. Lillian C. Szymusiak
(b) Address 1327 E. North Ave.

17 (a) Burial (b) Date thereof 4/28/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) APR 26 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25, 1947, at 2.40 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subarachnoid Hemorrhage, Spontaneous

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature Earl L Ryan M.D.
Medical Examiner.
Date signed 4-25-47

VS 151

Spec.—3-29-26—L. F. S.—500 Blks.

Exum B. Clark

G51093

HEALTH DEPARTMENT—CITY OF BALTIMORE

G51093

CERTIFICATE OF DEATH

1937

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 724 E. 41st ST., 9-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Exum B. Clark

(a) RESIDENCE NO. 724 E. 41st ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Peral O. Clark

7 DATE OF BIRTH (month, day, and year) April 24 1885

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
62		0	1	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Railway Mail Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) U.S.Government

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Exum B. Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknow

12 MAIDEN NAME OF MOTHER Unknow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknow

Informant Mr. Richard S. Ball

(Address) 724 E. 41 st St.

APR 26 1947, 19 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 25 1947

17 I HEREBY CERTIFY, That I attended deceased from Mar 11, 1947, to Apr 25, 1947, that I last saw h.im alive on Apr 24, 1947, and that death occurred, on the date stated above, at 8.45 A m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Hypertension C.V. Disease

(duration) 5 yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. W. Mack, M. D.

19 (Address) 513 E. 39th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	4/28/47
20 UNDERTAKER	ADDRESS
Wm. J. Tikner & Son	Northern Ave

G51094

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G51094

Please write the causes of death clearly and legibly. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1646 N. Gilmor St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1646 N. Gilmor St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John E. Smith

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Violet Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 7, 1893

8. AGE: Years 53 | Months 5 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimor, Md.
(Town, county, and state)

10. Usual Occupation Laborer
11. Industry or business Contractor

FATHER
12. Name John Smith
13. Birthplace Md.

MOTHER
14. Maiden Name Mary ?
15. Birthplace Md.

16 (a) Informant Violet Smith
(b) Address 1646 N. Gilmor St

17 (a) Burial (b) Date thereof 4/28/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. A. Nelson
(b) Address 1303 Pressman Street, Huntington for Pittsville, Md.

19 (Date received by registrar) APR 26 1947 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-25- 1947, at 4:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-8- 1946 to 4-25- 1947, and that I last saw h— alive on 4-24- 1947.

	Duration
Immediate cause of death: Cerebral Hemorrhage	2 Days
Due to: Hypertension	1 yr.
Due to:	
Other Conditions: Hemiplegia	1 yr.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George Page
Address 1516 N. Mount St (?) Date signed 4-[illegible]-47

VS 150

G51095

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G51095 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 428 Biddle st.
(c) Hospital or institution: 11

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 428 W. Biddle st
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** William Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/24/1881

8. AGE: Years 65 | Months 5 | Days — | If less than one day hr. min.

9. Birthplace Louisa Co. Va. (Town, county, and state)

10. Usual Occupation Mason

11. Industry or business

FATHER 12. Name John Henry Robinson
13. Birthplace Va.

MOTHER 14. Maiden Name Nettie Kelley
15. Birthplace Kentucky

16 (a) Informant Florence Houston
(b) Address 428 Biddle St.

17 (a) Louisa Co. Va. (Burial, cremation, or removal) (b) Date thereof 4/27/47 (month) (day) (year)
(c) Cemetery or crematory Va.
Location Louisa Co. Va.

18 (a) Funeral director Wm. H. Nelson
(b) Address 1303 Pennsylvania Ave

19 (a) APR 26 1947 (Date received by Registrar) Huntington Williams, M.D.

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-24-1947 at 7:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-15-1947 to 4-24-1947 and that I last saw h[illegible] alive on 4-24-1947.

Immediate cause of death	Duration
Uremia	10 days
Due to Nephrosclerosis	?
Due to Hypertension	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis E. Harman, M. D.
Address 2340 Madison Ave Date signed 4-28-47

G51096

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G51096

Please write plainly in ink. Use no abbreviations. Be sure to answer every question clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2727 Winchester St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2727 Winchester St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pauline Waldman Fink

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Franz Fink

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8, 1859

8. AGE: Years 88 | Months 1 | Days 17 | If less than one day hr. min.

9. Birthplace Dresden, Germany
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

MOTHER / FATHER

12. Name Unknown

13. Birthplace Germany

14. Maiden Name Eleanora Waldman

15. Birthplace Germany

16 (a) Informant Mr. Charles A. Fink

(b) Address 2727 Winchester St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 28, 1947 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cemetery

Location Baltimore, Md.

18 (a) Funeral director Keller & Amoroso

(b) Address 2310 Liberty Heights Ave.

19 APR 26 1947 (Huntington Williams, M.D. Registrar)

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 1947, at 1 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1945 to Apr. 25 1947.
and that I last saw her alive on Apr. 24 1947.

Immediate cause of death: Cardio-vascular-hypertension — Duration: 10 yrs

Due to: disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard A. Todd M. D.

Address 2108 St. Paul St. Date signed

X

G51097

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. G51097

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address W. J. Ross & Caton Aves
(c) Hospital or institution: St. Agnes Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 33 days
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 12 Glenwood ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Elma Musgrove

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3, 1935

8. AGE: Years	Months	Days	If less than one day
12	1	23	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Scholar
11. Industry or business School

FATHER
12. Name Harry T. Musgrove
13. Birthplace Md.

MOTHER
14. Maiden Name Maude R. Brandenburg
15. Birthplace Md.

16 (a) Informant Mrs Maude R. Brandenburg
(b) Address 12 Glenwood ave. Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 29, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. View Cem.
Location Howard Co., Md.

18 (a) Funeral director C. Harry Weer
(b) Address Lochearn, Md.

19 APR 26 1947 (Date Rec'd by Registrar) (b) Transcribed for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 April 1947, at 2:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 23 March 1947 to 26 April 1947 and that I last saw her alive on 25 April 1947

Immediate cause of death Carcinoma — Duration
Mucoid Anaplastic
Teratoid Ovary
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 28 March 47

Major findings of operation: Carcinoma of ovary with Metastases

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. E. Groth M.D. M. D.

Address St. Agnes Hosp. Date signed 26 Apr 47

VS 150

X

G51098

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56E

Registered G51098

Type or print plainly in ink. Fill all items. Underline the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address West Baltimore General Hosp.
(c) Hospital or institution: Rayner and Dukeland, Baltimore
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3102 Chelsea Terrace (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Emma Estella Pumphrey

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Harry B. Pumphrey

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 30, 1892

8. AGE: Years 54 | Months 6 | Days 26 | If less than one day ... hr. ... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name William Smith
13. Birthplace Anne Arundel Co. Md.

MOTHER
14. Maiden Name Mary B. Griffith
15. Birthplace Howard Co. Md.

16 (a) Informant Mrs Emma Maria Gorey
(b) Address 3102 Chelsea Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 27 1947 (month) (day) (year)
(c) Cemetery or crematory Melville Cemetery
Location Elkridge Md.

18 (a) Funeral director H. Lester Karp
(b) Address 5803 Main St. Elkridge Md.

19 (a) APR 26 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 April 1947 at 1:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 23 Apr 1947, to 25 April 1947, and that I last saw h[illegible] alive on 25 April 1947

Immediate cause of death Respiratory Failure — Duration 15 hrs
Circulatory collapse
Pulmonary edema
Due to Hypertensive CVD
Due to Adrenal tumor
Other Conditions Cerebral edema
Teeth extraction
(Include pregnancy within 3 months of death)
Date of operation 24 April 1947
Major findings of operation:
of autopsy: Pulmonary edema - Adrenal tumor

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Roy B. Turner M.D.
Address West Balt. Gen Hosp Date signed 25 April 47 M. D.

VS 150

X

G5:1099 B64 b 72735

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 157a

Registered No. G5:1099

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Corner Redwood & Green Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town ~~Baltimore~~ Sykesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Arthur Townsend

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 3/5/47

8. AGE: Years — | Months 1 | Days 20 | If less than one day ... hr. ... min.

9. Birthplace St. Agnes Hospital Balto Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name Authur B. Townsend
13. Birthplace Cambridge Maryland

MOTHER
14. Maiden Name Mildred Bell
15. Birthplace Savage, Maryland.

16 (a) Informant Authur B. Townsend
(b) Address Sykesville, Maryland.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 27 1947 (month) (day) (year)

(c) Cemetery or crematory Savage M. E. Cemetery
Location Savage, Maryland.

18 (a) Funeral director Easton Ford
(b) Address Elkton, Md.

APR 26 1941

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25, 1947 at 6 40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 16, 1947, to April 25 1947 and that I last saw him alive on April 25 1947.

Immediate cause of death	Duration
Anoxia	
Due to Respiratory Failure	
Due to Intra Cranial Birth Injury	
Other Conditions Malnourishment	

(Include pregnancy within 3 months of death)

Date of operation April 24, 1947

Major findings of operation: Hydrocephalus

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature ... M. D.
Address University Hospital Date signed 4-25-47

VS 150

X

G51100
CWK-106734

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 61

Register No. G51100

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4- 1- 16-
(e) Length of stay in Baltimore (yrs., mos., or days) 56- 8- 24-

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. E. Matthai Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Weeks, Eleanor Cranblitt

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Elisha E. Weeks
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) July 31-1890

8. AGE: Years 56 | Months 8 | Days 24 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joseph Cranblitt
13. Birthplace Maryland

MOTHER
14. Maiden Name Ellen ? Hamilton
15. Birthplace Meryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 28 47 (month) (day) (year)
(c) Cemetery or crematory Good Shepherd
Location Rockland Md.

18 (a) Funeral director Easton Sons Easton Md.
(b) Address Ellicott City, Maryland.

19 (a) APR 26 1947 (Date received by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 19 47 at 8:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 9 1946, to Apr. 25 1947, and that I last saw h er alive on Apr. 25 19 47.

Immediate cause of death: Respiratory Failure. — —
Due to: Uraemia — yrs.
Due to: Arteriosclerosis, gen'l. — yrs.
Due to: Diabetes Mellitus
Other Conditions: Lindau Anemia.
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy: Anemia, Lindau; Hypertrophied Prostate

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edmund B. Beacham M. D.
Address Balto City Hosp Date signed April 27 47

VS 150

X

G51101

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G51101

164c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Cecil (Harford)
(c) City or town Rocks (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Maynard J. Simmons

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Lola May Simmons
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) Aug. 7, 1898

8. AGE: Years	Months	Days	If less than one day
48	8	17	hr. min.

9. Birthplace Greenbriar County, W. Va. (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Jordan Simmons
13. Birthplace Greenbriar Co., W. Va.

MOTHER
14. Maiden Name Susanna Cutlip
15. Birthplace Greenbriar Co., W. Va.

16 (a) Informant Mrs. Lola Simmons
(b) Address Rocks, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/29/47 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Jarrettsville
Location Jarrettsville, Md.

18 (a) Funeral director W. H. Archer per Mahlon B. Mitchell
(b) Address Bynum, Md.

19 (a) APR 26 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25, 1947, at 4 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet Wound of Brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4/25/47 at 3:45 P.M.
(b) Where did injury occur? Rock, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearms - .22 cal. Rifle

23. Signature Earl L. Kaye M.D. Medical Examiner
Date signed 4-26-47

VS 191

G51102 — BALTIMORE CITY HEALTH DEPARTMENT — G51102

CERTIFICATE OF DEATH 469

Please write clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 641 N. Schroeder St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 641 N. Schroeder St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Milbrey

3 (b) If veteran, name war —
3 (c) Social Security Account No. 212-01-0596

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	Married

6 (b) Name of husband or wife Grace Milbrey
6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1896

8. AGE: Years	Months	Days	If less than one day
50	7	18	hr. min.

9. Birthplace Portsmouth, Va (Town, county, and state)
10. Usual Occupation Laundry man
11. Industry or business Archer Laundry

FATHER
12. Name George Milbrey
13. Birthplace Va.

MOTHER
14. Maiden Name Alice Burden
15. Birthplace Va.

16 (a) Informant Grace Milbrey
(b) Address 641 N. Schroeder St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/27/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bentley ave

19 (a) (Date received by registrar) (b) Registrar

R 27 1947
VS 150
Huntington Williams, M.D.

MEDICAL CERTIFICATION 2:45 PM

20. DATE OF DEATH 4/27 1947, at 2:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/20 1947 to 4/27 1947 and that I last saw h[illegible] alive on 4/20 1947

Immediate cause of death	Duration
Carcinomatosis	
Due to Carcinoma of Pancreas	approx. 1 yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Rayner Browne M. D.
Address 1300 E. 14th [illegible] St Date signed 4/[illegible]

Rayner Browne

G51103 BCHD 58991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G51103

Please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edmondson Ave. & Arceno St.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 709 Arlington ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Cheatham

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col	child

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 10/11/46 - 1946

8. AGE: Years	Months	Days	If less than one day
	6	18	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Wm Cheatham Sr.
13. Birthplace Va

MOTHER
14. Maiden Name Sarah Moore
15. Birthplace Md

16 (a) Informant Wm Cheatham Sr.
(b) Address 709 Arlington ave

17 (a) Burial (b) Date thereof 4 28 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director Williams & Jackson
(b) Address 916 Pennsylvania ave

19 (a) 4-27-1947 (b) Huntington Williams Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25, 1947 at 10:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 25 1947 to April 25 1947 and that I last saw him alive on April 25 1947.

Immediate cause of death	Duration
Toxemia	
Due to Bilateral Bronchio-Pneumonia	
Due to	
Other Conditions Meningismus, possible Meningitis	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.

Address University Hosp Date signed 4-25-47

G51104

CHARLES WADDY.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G51104 Registered No.

83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 504 Gold St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 504 Gold St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Chester Waddy
3 (b) If veteran, name war — 3 (c) Social Security Account No.
4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. M
6 (b) Name of husband or wife Lily Waddy
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) — — 1899.
8. AGE: Years 48 | Months — | Days — | If less than one day hr. min.
9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Porter
11. Industry or business Bakery

FATHER
12. Name George ? ?
13. Birthplace Va

MOTHER
14. Maiden Name Sarah ? ?
15. Birthplace ?

16 (a) Informant Edna Woodland
(b) Address 504 Gold St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 28 47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md
18 (a) Funeral director William A Jackson
(b) Address 916 Pennsylvania Ave
R 27 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/22 1947 M
21. I certify that death occurred on the date above stated; that I attended deceased from 4/20 1947 to 4/22 1947 and that I last saw him alive on 4/22 1947.

Immediate cause of death	Duration
Cerebral Apoplexy &	
Due to Paralysis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Ben Rhett M. D.
Address 2400 N. Charles St Date signed 4/28/47

Penalty for Withholding, Mutilating or Falsifying Certificate

VS 150

G51105

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V/31a

G51105 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1930 E. 28th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1930 E. 28th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Garner

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Edna A. Garner
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Apr 8. 1864

8. AGE: Years	Months	Days	If less than one day
83	0	16	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Retired Merchant
11. Industry or business Leather & Shoe Finding

FATHER
12. Name John H. Garner
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Christine Herold
15. Birthplace Baltimore Md

16 (a) Informant Edna A. Garner
(b) Address 1930 E. 28th St.

17 (a) Burial (b) Date thereof Apr 28 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Balto Co. Md

18 (a) Funeral director Mrs. Mrs. John W. Teufel & Son
(b) Address 5311 Edmondson Ave

19 (a) (b)
(Date rec'd by registrar) Evelyn Williams M.D.

APR 29 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 24 1947, at 9 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1947 to April 24 1947, and that I last saw him alive on April 24 1947.

Immediate cause of death	Duration
Bronchopneumonia	3 d
Uraemia Coma	5 d
Due to Arterio Sclerosis	6 wk.
Hypertension	5 yr
Due to Chronic Interstitial Nephritis	5 yr
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. A. Stevens M. D.
Address 2878 Harford Rd Date signed 4-25-47

X

G51106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G51106 Registered No.

Please write clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3142 Remington Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 70 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3142 Remington Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Blanche E. Bradford

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife John H. Bradford

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 26-1866

8. AGE: Years 80 | Months 4 | Days 29 | If less than one day ..... hr. ..... min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Jacob Masimer
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Unknown
15. Birthplace Pennsylvania

16 (a) Informant Mrs. Grace B. Hackett
(b) Address 3142 Remington Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 28-1947 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore Co. Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) ..... (b) .....
(Date rec'd by registrar) Registrar

APR 27 1947
V S 150
Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 1947, at 12 Noon

21. I certify that death occurred on the date above stated; that I attended deceased from 5/18/1946, to 4/25/1947, and that I last saw her alive on 4/25/1947.

Immediate cause of death	Duration
Bronchopneumonia	
Cardiac Failure	
Due to Hypertension	
Due to Arteriosclerosis	
Cardio Vascular Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. Hersa M. D.
Address 2902 Huntington Ave. Date signed 4/26/47

X

G51107

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

G51107 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2719 N. Howard St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2719 N. Howard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna M. Dinamore.

3 (b) If veteran, name war –

3 (c) Social Security Account No. –

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married.

6 (b) Name of husband or wife Alvin B. Dinamore

6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Jan 29, 1885

8. AGE: Years 62 | Months 2 | Days 26 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Benjamin Lowman
13. Birthplace Maryland.

MOTHER
14. Maiden Name Alice Zigler
15. Birthplace York, Pa.

16 (a) Informant Alvin B. Dinamore Sr.
(b) Address 2719 N. Howard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apl 28/47 (month) (day) (year)
(c) Cemetery or crematory Morland Park
Location Taylor Ave

18 (a) Funeral director Edmondson & Donovan
(b) Address 3615-17 Huntington Ave.

19 (a) Date received by registrar APR 27 1947 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1947 at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 24 1947, to April 24 1947, and that I last saw her alive on April 24 1947.

Immediate cause of death Carcinoma of Pancreas — Duration 8 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Manuel Levin M. D.
Address 4818 Reisterstown Rd Date signed April 24/47

X

G51108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54a

G51108 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hosp. W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 816 St Paul St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Edith Shirley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Wm. G. Shirley

6 (c) If alive, give age Years

7. Birth date of deceased (mo., day, yr.) Oct 9, 1894

8. AGE: Years 52 | Months 6 | Days 18 | If less than one day hr. min. 1894

9. Birthplace Pa (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John F. Menemaker

13. Birthplace Pa

MOTHER 14. Maiden Name Emma Richmond

15. Birthplace Pa

16 (a) Informant Wm A. Shirley

(b) Address 816 St Paul St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 30, 1947 (month) (day) (year)

(c) Cemetery or crematory Prospect Hill

Location York Pa

18 (a) Funeral director H. Kenworth & Daneker

(b) Address 2415-17 Chestnut Ave.

19 (a) (Signature of undertaker or agent) (b) Huntington Williamsport Md

APR 27 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/23 1947, to 4/27 1947, and that I last saw her alive on 4/27 1947.

	Duration
Immediate cause of death Resp. failure	
Due to Heart Chary failure	—
Due to Increased intracranial pressure	4 days
Other Conditions. Malignant Brain Tumor (Interval between pregnancy within 6 months of death)	

Date of operation

Major findings of operation: Glioblastoma multiforme - rt parietal region

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. H. N. Crosby, M.D.

Address Univ Hosp. Baltimore Md Date signed 4/27/47

G51109 BALTIMORE CITY HEALTH DEPARTMENT G51109

CERTIFICATE OF DEATH 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1709 Wenner Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1709 Wenner Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Olga Stern

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Max

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 21 - 1871

8. AGE: Years 76 | Months 3 | Days 5 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Samuel Benjamin

13. Birthplace Germany

MOTHER 14. Maiden Name Johannah

15. Birthplace Germany

16 (a) Informant Mrs Gertrude Goldenheimer

(b) Address 1709 Wenner ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-27-47 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Philp Rd & Hamilton ave

18 (a) Funeral director Jack Lewis Inc

(b) Address 1429 E Baltimore St

R 27 1947 (Date received by registrar) (b) Huntington Williams, MD Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-26- 1947, at 1:29 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1947 to 4-26 1947 and that I last saw her alive on 4-26 1947.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harold H. Bix M. D.

Address 2516 Linden Ave Date signed 4-27-47

G51119

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G51119 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hosp.
(c) Hospital or institution:
Redwood & Greene Sts.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town W. Brooklyn
(If outside city or town limits, write RURAL and give town)
(d) Street No. 161 Prospect Park
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Arthur Cogan

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. single.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1st 1941

8. AGE: Years 5 | Months 11 | Days 25 | If less than one day hr. min.

9. Birthplace Brooklyn N.Y.
(Town, county, and state)
10. Usual Occupation None.
11. Industry or business

FATHER
12. Name Arthur Cogan
13. Birthplace Brooklyn N.Y.

MOTHER
14. Maiden Name Alicia E. Caldwell
15. Birthplace Liberty Grove, Md.

16 (a) Informant Mrs. Alicia Cogan
(b) Address 161 Prospect Park W. Brooklyn N.Y.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/29/47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem.
Location Brooklyn N.Y.

18 (a) Funeral director John J. Cosgrove Son
(b) Address 900 03 Fulton St

19 (a) Rec'd by registrar (b) Washington Williams M.D. Registrar
7 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-26 1947, at 1 59 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-25 1947, to 4-26 1947, and that I last saw him alive on 4-26 1947.

Immediate cause of death	Duration
Encephalitis	
Due to Encephalitis	
Due to	
Other Conditions Pneumonia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Cerebral edema & Pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gerald A. Martin M.D.
Address University Hosp. Date signed 4-26-47

G51111

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G51111 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1221 So. Carey St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1221 So. Carey St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maggie E. Harvey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife John E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 31st 1869

8. AGE: Years	Months	Days	If less than one day
77	7	25	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation house-work
11. Industry or business at home

FATHER
12. Name Peter Theodore
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Annie Craig
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. John E. Harvey
(b) Address 1221 So. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/28/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Mem.
Location Woodlawn Md.

18 (a) Funeral director John J. Cannon & Son
(b) Address 901-03 Hollins St

19 (a) (b) Date received by Registrar Huntington Williams M.D.

APR 29 1947
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25th 1947, at 2.45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 18 1946, to 4/25/ 1947, and that I last saw her alive on 4/24/ 1947.

Immediate cause of death Arterio sclerotic heart disease — Duration 6 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 126 Hanover St Date signed 4/26/47

X

G51112

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G51112 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 816 Brooks Lane.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Years.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 816 Brooks Lane.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARY STERN.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Samuel H. Stern.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 2, 1859.

8. AGE: Years 87 | Months 4 | Days 24 | If less than one day hr. min.

9. Birthplace Johnstown, Pa.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Moses Cohen,
13. Birthplace Germany.

MOTHER
14. Maiden Name Caroline Hecht,
15. Birthplace Germany.

16 (a) Informant Mr. Martin Stern,
(b) Address Beverly Hills, Cal.

17 (a) Cremation (b) Date thereof 4/28/47.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount.
Location Balto. Md.

18 (a) Funeral director Garrick Funeral Chapel
(b) Address 1902 Eutaw Place.

19 (a) Filed by registrar 4/28/47 (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26th. 1947, at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 9 1947 to April 26 1947, and that I last saw h[illegible] alive on April 26 1947.

	Duration
Immediate cause of death: Carcinoma of colon	2 yrs
Due to: Myocardial failure	1 year
Due to:	
Other Conditions: arteriosclerosis	8 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Frederick Lentz
Address Temple Garden Apts. Date signed 4/D/1947

VS 150

41934 G51113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G51113

Type or print clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County .....
(c) City or town Long Island (If outside city or town limits, write RURAL and give town)
(d) Street No. 9001-204 St Hollin (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3 (a) FULL NAME Bessie Aronson

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	Widow

6 (b) Name of husband ~~or wife~~ Calman Aronson
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 12-18-1873

8. AGE: Years	Months	Days	If less than one day
73	4	9	..... hr. ..... min.

9. Birthplace Austria (Town, county, and state)
10. Usual Occupation .....
11. Industry or business .....

FATHER
12. Name Gershia Sperber
13. Birthplace Austria

MOTHER
14. Maiden Name Rose Shieant
15. Birthplace .....

16 (a) Informant .....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 4/27/47 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery ~~or crematory~~ Mt. Carmel
Location Long Island New York

18 (a) Funeral director Harris Sindelbrim & Son
(b) Address 1802 Eutaw Place

19 (a) ..... (b) ..... Registrar
~~Filed~~ 'd by registrar 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 1947 at 5-40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-21- 1947 to 4-27- 1947 that I last saw her alive on 4-27- 1947

Immediate cause of death	Duration
Myocardial infarction	7 d
Due to Hypertensive cardio-vascular disease	7
Due to	.....
Other Conditions	.....

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury .....

23. Signature Marvin B. Day M. D.
Address Johns Hopkins Hosp. Date signed 27 Apr 47

G51114

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G51114

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1210 E 33rd St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1210 E 33rd St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hirom Block

3 (b) If veteran, name war W
3 (c) Social Security Account No. None

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Elizabeth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 28. 1884

8. AGE: Years 63 | Months 2 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county and state)

10. Usual Occupation Beauty Shop

11. Industry or business

FATHER 12. Name Herman Block
13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Emma Prima
15. Birthplace Md

16 (a) Informant Elizabeth Block
(b) Address 1210 E 33rd St

17 (a) Burial (b) Date thereof 4 28 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Baltimore Co Md

18 (a) Funeral director Thomas J. Fox
(b) Address 1210 E Pau St
(c) Date rec'd by registrar 4 27 1947 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 1947, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1947 to April 26 1947
and that I last saw him alive on April 26 1947

Immediate cause of death Coronary Thrombosis

Due to Chronic Myocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration 4 yrs 3 mos 11 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Williams H. Rysavy M. D.
Address 801 N Broadway Date signed 4-28-47

VS 150

G51115

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G51115 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution:
Elmhurst Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1614 Ellamont Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Burton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Harry H. Burton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 28, 1881

8. AGE: Years	Months	Days	If less than one day
65	7	26	hr. min.

9. Birthplace Rosedale, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Vernon Klage
(b) Address 1614 Ellamont Street

17 (a) Burial (b) Date thereof 4/28/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) (b)
(Date received by registrar)

APR 27 1947
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24, 1947, at 8:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1946 to Apr 24 1947, and that I last saw h[illegible] alive on Apr. 24 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Art. Atherosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis Isaacs M. D.
Address 1700 Eutaw Pl. Date signed 4-25-47

X

G51116 BALTIMORE CITY HEALTH DEPARTMENT G51116

CERTIFICATE OF DEATH 47

Registered No.

Please answer questions clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4916 Midwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4916 Midwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Otillie Spath

3 (b) If veteran, name war W
3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Frank

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1893

8. AGE: Years 73 | Months 11 | Days — | If less than one day hr. min.

9. Birthplace Vienna Austria (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Unknown Stangl
13. Birthplace Austria

MOTHER 14. Maiden Name Elizabeth Roenbeck
15. Birthplace Austria

16 (a) Informant Frank Spath
(b) Address 4911 Midwood Ave

17. Burial (Burial, cremation, or removal) (b) Date thereof 4/28/47 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director William J. Dyer
(b) Address 1219 E. Fort Ave

19 (a) (Date received by registrar) (b) Registrar

R 28 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25, 1947, at 11:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 17, 1947 to April 25 47 and that I last saw h. or alive on April 25, 1947

Immediate cause of death	Duration
Carcinoma of Lungs.	1 yr.
Due to	
Due to	
Other Conditions Chronic Myocarditis 3yrs	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert G. Ringrose M. D.

Address 1613 E. North Ave Date signed 4-26-47

X

HEALTH DEPARTMENT—CITY OF BALTIMORE

G51117 G51117

CERTIFICATE OF DEATH 877

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 4500 Mainfield Ave St. ✓ Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ....yrs....mos....ds. How long in U. S. If of foreign birth?....yrs....mos....ds.

2. FULL NAME HELEN E. MOTZ. ✓

If U.S. Veteran specify WAR .....

(a) Residence: No. 4500 MAINFIELD Ave St., ... Ward. .....

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

3a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day, year) June 10th 1916

7. AGE Years	Months	Days	If LESS than 1 day,....hrs. or....min.
30	10	16	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. —

10. Date deceased last worked at this occupation (month and year) X

11. Total time (years) spent in this occupation X

12. BIRTHPLACE (city or town) (State or country) Balto. Md.

FATHER

13. NAME Thomas C. Motz

14. BIRTHPLACE (city or town) (State or country) Waynesboro Pa.

MOTHER

15. MAIDEN NAME Ruth M. Currens

16. BIRTHPLACE (city or town) (State or country) Fairfield Pa.

17. INFORMANT Thomas C. Motz

(Address) 4500 Mainfield Ave

18. BURIAL, CREMATION, OR REMOVAL

Place Parkwood Date 4/29 1947

19. UNDERTAKER William Cook Inc

(Address) 1217 E. Paul St

APR 27 1947 Penn. Station for Willis Shaffer

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 4/26, 1947

22. I HEREBY CERTIFY, That I attended deceased from July 27 to April 26 1947

last saw her alive on 4/21 1947 Death is said to have occurred on the date stated above, at 11:12 A m.

The principal cause of death and related causes of importance were as follows:

Multiple sclerosis — Duration 10 yrs

Other contributory causes of importance:

Was an operation performed? No Date of .....

For what disease or injury? —

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? .....Date of injury....., 19....

Where did injury occur? —

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No If so, specify .....

(Signed) Walter E. Bonfoey M. D.

(Address) 4331 Hayford Rd

X

G51118

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

G51118

Registered No.

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun
(c) Hospital or institution Franklin Square Hosp. 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 937 Ridgely St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Victoria Emma Eckhardt
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) ~~Single, married~~, widowed, or divorced Widowed
6 (b) Name of husband Francis Earl Eckhardt Sr.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec 31st 1887
8. AGE: Years 59 | Months 4 | Days 5 | If less than one day 26 hr. min.
9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Operator Confectionery
11. Industry or business Own

FATHER
12. Name Wm Spangler
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Anna Schnell
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Anna Eckhardt
(b) Address 937 Ridgely St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/29/47 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. Md.
18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.
Apr 27 1947 Date received by Registrar Livingston Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/26 1947 at 7.01 A M
21. I certify that death occurred on the date above stated; that I attended deceased from 4/25 1947 to 4/26 1947 and that I last saw her alive on 4/26 1947
Immediate cause of death Generalized Peritonitis
Due to PERFORATION OF SIGMOID COLON
Due to DIVERTICULOSIS SIGMOID
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 4/26/47
Major findings of operation: PERITONITIS INTESTINAL PERFORATION
of autopsy: AS ABOVE
Duration Stop ?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature W. Norton Gratz M. D.
Address Franklin Square Hosp Date signed 4/26/47

G51119

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46M

Registered No. G51119

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution:
University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore - 23
(If outside city or town limits, write RURAL and give town)
(d) Street No. 418 S. Fant Hill Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lewis Anger JR

3 (b) If veteran, name war —

3 (c) Social Security Account No. 413-09-1996

4. Sex	5. Color or race	6 (a) ~~Single, married, widowed~~, or divorced.
M	W	D

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 10/27/1885

8. AGE: Years	Months	Days	If less than one day
61	5	27	____ hr. ____ min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Time Clerk

11. Industry or business Auto-Sales Book

FATHER
12. Name Louis Anger
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Schachmann
15. Birthplace Maryland

16 (a) Informant Patient
(b) Address Above

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/28/47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director J. B. Hilgert Son
(b) Address 1510 W. Baltimore St

19 (a) ____ (b) ____ (Date received by registrar) ____ Registrar

APR 27 1947

Vs 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-24 1947, at 9:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-19 1947 to 4-24 1947 and that I last saw him alive on 4-24 1947.

Immediate cause of death	Duration
Generalized Carcinomatosis metastatic from GI Tract	
Due to	
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation 4-2-47

Major findings of operation: Generalized Carcinomatosis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Guy L. Riggs M. D.

Address Univ. Hosp. Date signed 4-24-47

G51120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 47c

G51120 Registered No.

Please write clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Westminster Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 37 Union Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hattie Hendrickson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife George Hendrickson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years 57 | Months 2 | Days 7 | If less than one day ..... hr. ..... min.

9. Birthplace Westminster Carroll Co. Md.
(Town, county, and state)

10. Usual Occupation Home - servant

11. Industry or business

FATHER
12. Name James Brightsfield
13. Birthplace Westminster Md.

MOTHER
14. Maiden Name Annie Aguirrell
15. Birthplace Carroll Co. Md.

16 (a) Informant James Brightsfield
(b) Address Union St - Westminster, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 30/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Ellicott Cem.
Location Westminster, Md.

18 (a) Funeral director J. E. Myers, Jr.
(b) Address Westminster, Md.

19 (a) (Signature of local registrar) Huntington Williams, M.D. Registrar
(b) Date rec'd by local registrar

APR 28 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 1947 at 2:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-3-1947 to 4-27-1947 and that I last saw her alive on 4-27-1947

Immediate cause of death Respiratory Failure — Duration
Due to Pleural Effusion
Due to Probable Bronchogenic Carcinoma.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Finley M. D.

Address Univ. Hosp. Date signed 4-27-47

X

G51121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V100B

Registered No. G51121

Please write clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene + Lombard
(c) Hospital or institution: University Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 603 Lennard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Dora Kaiser

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Thomas H
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 22, 1888

8. AGE: Years	Months	Days	If less than one day
59	1	3	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry Edel
13. Birthplace Germany

MOTHER
14. Maiden Name Johanna
15. Birthplace Germany

16 (a) Informant Mr Thomas H Kaiser
(b) Address 603 Linnard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 28 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3501 Frederick Rd

18 (a) Funeral director Harry H Wetzler
(b) Address 410 Edmondson Ave

19 APR 28 1947 (Date rec'd by registrar) Washington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-25- 1947 at 4 47 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/10 1947 to 4-25 1947 and that I last saw h er alive on 4-25 1947.

Immediate cause of death Pulmonary embolism — Duration
Due to Thrombophlebitis left leg —
Due to Pulmonary infarcts left + Right —
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: 4-25-47

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George Y Massenburg M.D.
Address University Hosp Date signed 4/25/47

VS 150

G51122

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V108

Registered No. G51122

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 22

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1517 W. Mulberry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Green

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race N

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Rosie Green

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/17/1904

8. AGE: Years 42 | Months 6 | Days 6 | If less than one day hr. min.

9. Birthplace Sanford, Fla (Town, county, and state)

10. Usual Occupation Longshoreman

11. Industry or business

FATHER: 12. Name unknown
13. Birthplace Florida

MOTHER: 14. Maiden Name unknown
15. Birthplace Florida

16 (a) Informant Rosie Green
(b) Address 1004 Gutaw Street

17 (a) Burial (Burial, cremation, or removal) (b) [illegible] (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary 4/30/47
Location Cedar Hill, Md.

18 (a) Funeral director A. Appleton
(b) Address 98 Druid Hill Ave.

19 (a) APR 28 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/23 1947 at 5:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/20 1947 to 4/23 1947, and that I last saw him alive on 4/23 1947.

Immediate cause of death Emphysema

Due to Lobar Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gilbert L. Trapnell M. D.
Address Marden Bldg. Date signed 4/25/47

G51123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registration No. G51123

Please answer all questions completely and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai
(c) Hospital or institution: Mount Rutland 24
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Balto (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 915 S Highland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Hughes
3 (b) If veteran, name war
3 (c) Social Security Account No. 213-05-3081

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15 1888

8. AGE: Years	Months	Days	If less than one day
58	9	12	hr. min.

9. Birthplace Wales (Town, county, and state)
10. Usual Occupation Bush Tender
11. Industry or business

FATHER
12. Name David Hughes
13. Birthplace Wales

MOTHER
14. Maiden Name Jane Davis
15. Birthplace Wales

16 (a) Informant Miss Hannah Hughes
(b) Address 915 S Highland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 30 47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto
18 (a) Funeral director Wm. Lund & Sons
(b) Address 2007 Orleans St Thurlington Williams, Mgr.
19 (a) (b) Registrar

APR 28 1947

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-26 1947, at 7:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-21 1947, to 4-26 1947, and that I last saw her alive on 4-26 1947

Immediate cause of death Myocardial Infarct — Duration
Due to Hypertension
Due to Chronic Nephritis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nathan B Hyman M. D.
Address Sinai Hospital Date signed 4-26-47

G51124

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Lemke 107

Registered No. G51124

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Brown St.
(c) Hospital or institution: University Hospital 76
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto 15
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3422 Kenyon (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Lemke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Widowed

6 (b) Name of husband or wife Louis Lemke

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 16 1863

8. AGE: Years	Months	Days	If less than one day
83	7	12	hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER 12. Name Ferd Nordengen

13. Birthplace Ger

MOTHER 14. Maiden Name Dont Know

15. Birthplace

16 (a) Informant Mrs E L Knachel

(b) Address 3422 Kenyon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 30 47 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Balto Co Md

18 (a) Funeral director Uhland Funeral Home

(b) Address 2008 Arlington

19 (a) Filed by [illegible] Registrar

APR 28 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 1947, at 9 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 19 1947 to April 27 1947, and that I last saw her alive on April 27 1947.

Immediate cause of death Circulatory failure

Due to Bronchopneumonia, contributory, Cerebral

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles R Johns M. D.

Address Univ Hospital Date signed 4/27/47

X

G51125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G51125

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4222 Springwood
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4222 Springwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara F. Schnauffer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Chas W. Schnauffer

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 4th 1884

8. AGE: Years 62 | Months 7 | Days 22 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, (Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER 12. Name Frank Schlegel

FATHER 13. Birthplace Germany

MOTHER 14. Maiden Name Elizabeth Schmaltz

MOTHER 15. Birthplace Germany

16 (a) Informant Charles W. Schnauffer Jr

(b) Address 4505 Selby Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year) Apr 29

(c) Cemetery or crematory Parkwood Cem

Location Rural

18 (a) Funeral director Ulrich Funeral Home

(b) Address 2008 Adams St

19 (a) Filed APR 28 1947 (b) Thurlington Williams M.D. Registrar

V S 190

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 1947, at 1.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 13 1947, to April 26 1947, and that I last saw h[illegible] alive on April 25 1947.

Immediate cause of death	Duration
Congestive Heart Failure	5 days
Due to Coronary Thrombosis	5 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Adam J. Lewis M. D.

Address 6232 Belair Road Date signed 4/26/47

C51126 TN. 107635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. C51126

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 26-12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-mo. 27 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Duncan McKay or McKay Duncan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Seperated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 14th 1883

8. AGE: Years	Months	Days	If less than one day
63	4	28	..... hr. ..... min.

9. Birthplace Scotland
(Town, county, and state)

10. Usual Occupation Marine Pipe Fitter

11. Industry or business

FATHER
12. Name Duncan McKay
13. Birthplace Scotland

MOTHER
14. Maiden Name Genney McFaland White
15. Birthplace Scotland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School APR 21 1947

18 (a) Funeral director Commissioner of Health

(b) Address

APR 28 1947 (Date rec'd by Registrar) Harold J. Williams, M.D.

MEDICAL CERTIFICATION P

20. DATE OF DEATH April 12th 1947, at 10.37 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 15 1947 to Apr. 12 1947, and that I last saw him alive on Apr. 12 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Bronchopneumonia	pneu
Due to Bronchogenic Carcinoma	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Doyle Waldron M. D.
Address B. C. H. Date signed 4-17-47

VS 150

51127 City Dispensary Bk #4 - 16365

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G51127
Registered No.

Please write plainly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. ward 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 912 Roduman Way #5
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Nunnelly.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Wh.	S.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-12-47

8. AGE: Years	Months	Days	If less than one day
Newborn			8 hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Newborn
11. Industry or business

FATHER
12. Name Leonard Erwin Nunnelly
13. Birthplace Dinwiddy, Va.

MOTHER
14. Maiden Name Doris Traylor
15. Birthplace Nottoway, Va.

16 (a) Informant Mother
(b) Address same.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Lo[illegible] Hopkins Medical Schoo[illegible] APR 24 1947
18 (a) Funeral director Commissioner of Health
(b) Address
APR 28 1947 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1947, at 2P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9AM 4-12 1947, to 2PM 4-12 1947, and that I last saw her alive on 4-12 1947.

Immediate cause of death	Duration
Anoxia	
Due to atelectasis	
Due to prematurity	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: atelectasis + prematurity

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Gerald A. Martin M. D.
Address University Hosp. Date signed 4-14-47

VS 150

128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. C51128

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: 700 Fleet Street
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED: Found in a box car at Piers 11 Canton Balto
(a) State W. Va. (b) County.....
(c) City or town Kimball
(If outside city or town limits, write RURAL and give town)
(d) Street No.....
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Floyd Denton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	COLORED	?

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1907

8. AGE: Years	Months	Days	If less than one day
40			.....hr. .....min.

9. Birthplace.....
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a).....(b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory.....
Location University Medical School

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) APR 28 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

APR 25 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1947, at 3 35 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH.....
Lobar pneumonia, of right lower lung

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature George G. Merrill M.D.
Medical Examiner.

Date signed 4/14/47

VS 151

1129

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

158

Registered No. G51129

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 627 W. Mulberry St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME MARIE RUFFIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/26/47

8. AGE: Years	Months	Days	If less than one day
	1	21	.....hr. .....min.

9. Birthplace.....
(Town, county, and state)

10. Usual Occupation Unknown
11. Industry or business

FATHER
12. Name.....
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant.....
(b) Address

17 (a).....(b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory.....
Location University Medical School APR 25 1947

18 (a) Funeral director Commissioner of Health
(b) Address.....

APR 28 1947 Winston Williams M.D.
(Date filed by Registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17, 1947 at 10.25 a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH.....
Malnutrition

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature Earl L. Royer M.D.
Medical Examiner

Date signed 4-17-47

X

5 1130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 87E

G51130 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 Carson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Martha Gosnell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Col

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1903

8. AGE: Years 44 Months Days If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Richard Harris

13. Birthplace Md.

MOTHER 14. Maiden Name Mary ?

15. Birthplace ?

16 (a) Informant Martha Gosnell

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School APR 25 1947

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) APR 28 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-19 1947, at 4:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-5 1947 to 4-19 1947, and that I last saw h[illegible] alive on 4-19 1947.

Immediate cause of death	Duration
Atelectasis	
Due to intra-uterine hydrocephalus	
Due to Fetal Malformation etiology	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 4-17-47

Major findings of operation: No cause of hydrocephalus found

of autopsy: Negative Chromosomal aberrations

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. B. Harley, M.D. M. D.

Address Univ. Hosp. Date signed 4-20-47

VS 150

51131 JL -16146

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G51131

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 - 6 -16 26 12
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Street Address (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Joseph Summerville

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1879

8. AGE: Years	Months	Days	If less than one day
68	1	21	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Isiah
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth
15. Birthplace Md.

16 (a) Informant H. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School APR 21 1947

18 (a) Funeral director Commissioner of Health
(b) Address
APR 28 1947 (Date received by registrar) (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1947, at 2.30A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 27 1932, to Apr. 13 1947, and that I last saw h. 1m alive on April 13 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Senility	
Due to Generalized arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Doyle Waldron M. D.
Address B. C. H. Date signed 4-18-47

VS 150

X

51132 BC# B-75709

BALTIMORE CITY HEALTH DEPARTMENT ✓ G51132

CERTIFICATE OF DEATH 159 Registered No.

Type or print plainly in ink. Fill all spaces or write NONE where necessary. Sign and file certificate with Registrar of Vital Statistics within 24 hours after death.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green St
(c) Hospital or institution: Univ. Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1700 Pierce St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Steele

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: B | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-9-47

8. AGE: Years | Months | Days: 2 | If less than one day: hr. min.

9. Birthplace Univ. Hospital, Balt, Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Robert Woods

13. Birthplace N. C.

MOTHER 14. Maiden Name Mary Woods

15. Birthplace N. C.

16 (a) Informant Mary Steele
(b) Address 1700 Pierce St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School

18 (a) Funeral director

(b) Address

APR 28 1947 (Date rec'd by Registrar)

APR 21 1947
Commissioner of Health

Kathryn Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-11 1947, at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-9 1947 to 4-11 1947 and that I last saw h[illegible] alive on 4-11 1947

Immediate cause of death: Respiratory Failure — Duration

Due to: Prematurity

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Waughn, M. D.

Address Univ. Hospital Date signed 4-14-47

VS 150

X

G5I133

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G5I133

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2540 Lauretta Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Maryland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2540 Lauretta Ave. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Osmund L. Wenderoth

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	217-03-0657

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Elizabeth Wenderoth
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) June 2, 1893

8. AGE: Years	Months	Days	If less than one day
53	10	24	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Sheet Metal Worker
11. Industry or business ?

FATHER
12. Name William Wenderoth
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mary O'Brien
15. Birthplace Irland

16 (a) Informant Elizabeth Wenderoth
(b) Address 2540 Lauretta Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/29/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Maryland

18 (a) Funeral director Geo. M. Little
(b) Address 2700 Edmondson Ave.

19 APR 28 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26, 1947, at 9 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1946, to April 26 1947, and that I last saw him alive on April 26 1947.

Immediate cause of death	Duration
Heart Failure	8 weeks
Due to Pneumonia Coronary Thrombosis	7
Due to Arteriosclerosis Gen'l.	
Other Conditions Emphysema Polycythemia, Adenocarcinoma Jaw (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. T. Lisansky M.D. M. D.
Address 3210 Liberty Heights Date signed 4/28/47

VS 150

51134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 46 B

Registered No. G51134

Give the causes of death clearly and legibly. Approx.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Somerset
(c) City or town Crisfield
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME
Walston, Charles M.

3 (b) If veteran, name war	3 (c) Social Security Account No. 217-03-1056

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1879

8. AGE: Years	Months	Days	If less than one day
67	6	15	hr. min.

9. Birthplace Somerset Co. Md.
(Town, county, and state)
10. Usual Occupation Merchant Seaman
11. Industry or business Seafarer

FATHER
12. Name Charles Walston
13. Birthplace Md.

MOTHER
14. Maiden Name Indianna Pruitt
15. Birthplace Md.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 29/47 (month) (day) (year)
(c) Cemetery or crematory Crisfield Cemy.
Location Crisfield, Md.

18 (a) Funeral director John O. Mitchell Hse.
(b) Address 1900 Eutaw Place

19 APR 28 1947 (Date rec'd by registrar) (c) Huntington-Williamson, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 1947 at 9:12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 23 1947 to Apr. 27 1947 and that I last saw h. 1m alive on Apr. 27 1947.

Immediate cause of death: Carcinoma of stomach with metatases — Duration: FOUR YEARS

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 4/28/47

VS 150

X

G51135

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

G51135 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Prince George
(c) City or town Laurel.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 116 Washington Blvd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Casper Kaiser

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	✓

6 (b) Name of husband or wife Mrs Minnie E. Kaiser
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 29 1877

8. AGE: Years	Months	Days	If less than one day
69	3	30	hr. min.

9. Birthplace Md
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs Minnie E Kaiser
(b) Address Laurel Md
17 (a) Burial (b) Date thereof April 30 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Ivy Hill
Location Laurel Md
18 (a) Funeral director De Witt Davidson
(b) Address Laurel
19 APR 28 1947 (b) Huntington-Williams Mort
(Date rec'd by registrar) Registrar

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28 1947, at 2:47 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 21 1947, to April 28 1947, and that I last saw him alive on April 28 1947.

Immediate cause of death	Duration
Cardiac Failure	
Due to Hypertension and	
Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James Ellis Wade jr. M. D.
Address Bon Secours Hosp. Date signed 4/28/47

X

G51136

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered G51136

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Sinai Hospital
(b) Street address
(c) Hospital or institution:
Monument & Rutland Ave 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3622 Cottage ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE M FELDMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Late Amalie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation
11. Industry or business Jeweler Business

FATHER
12. Name Mayer Feldman
13. Birthplace Russia

MOTHER
14. Maiden Name Etta ?
15 Birthplace Russia

16 (a) Informant Irvin S Friedman
(b) Address 3315 Powhatan Ave

17 (a) Burial (b) Date thereof April, 28, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Workmen Circle Cemetery
Location Mt Carmel Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) APR 28 1947 Huntington Williams M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/27 1947, at 2 1/2 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/26 1947 to 4/27 1947, and that I last saw h. alive on 4/27 1947

Immediate cause of death	Duration
Coronary Occlusion	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature S M Feldman M.D.
Address Forest Hosp. Date signed 4/27

V S 150

51137 BC# G76808 107

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G51137

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 668 Sarahanne St
(c) Hospital or institution: 4

(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 668 Sarahanne St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mickard Clinton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 24, 1947.

8. AGE: Years	Months	Days	If less than one day
~	~	2	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Fielder.
13. Birthplace Manning, S. C.

MOTHER 14. Maiden Name Doris C. Clinton.
15. Birthplace Baltimore, Md.

16 (a) Informant Victoria Clinton.
(b) Address 688 Sarah Anne St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 28 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 3344 Schroeder St

19 (a) APR 28 1947 (Date rec'd by registrar) (b) Huntington Williams, Md.

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MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 1947, at 9:30 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature Earl L Royer M.D. Medical Examiner.
Date signed 4-26-47

X

G51138

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G51138

94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1621 N Broadway St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No. Route #4
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jesse Maurice Stouch

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 213-01-9982

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Gertrude E. Stouch

6 (c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): Oct. 20, 1875

8. AGE: Years 71 | Months 6 | Days 7 | If less than one day ____hr. ____min.

9. Birthplace: Carroll County, Maryland
(Town, county, and state)

10. Usual Occupation: Salesman

11. Industry or business: Groceries

FATHER
12. Name: George Stouch
13. Birthplace: York, Penna.

MOTHER
14. Maiden Name: Rebecca Bowers
15. Birthplace: Maryland

16 (a) Informant: Mrs. Gertrude E. Stouch
(b) Address: Westminster, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Apr. 29/47 (month) (day) (year)
(c) Cemetery or crematory: Westminster Cem.
Location: Westminster, Maryland

18 (a) Funeral director: J. Francis Reese
(b) Address: Westminster, Md.

19 APR 28 1947 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 1947, at 2 00 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: William J. Hetherington M.D.
Medical Examiner.
Date signed: April 28 1947

G51139

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

Registered No. G51139

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [illegible] St.
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1428 Holbrook St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank Lannon

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife Single
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 19, 1891

8. AGE: Years	Months	Days	If less than one day
55	8	7	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Retired Police
11. Industry or business Balto. City Police Dept.

FATHER
12. Name John P. Landon
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Julia Agnes Mullin
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Ernest P. Grove
(b) Address 1428 Holbrook St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 28 1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cemetery
Location 4300 Old Frederick Rd

18 (a) Funeral director Elmer W. Conklin Sons
(b) Address 924 E. Eager St.

19 APR 28 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/26/47 19..., at 11:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/2/47 19..., to 4/26/47 19..., and that I last saw h... alive on 4/26/47 19....

	Duration
Immediate cause of death: Uremia	24 days
Due to: Pyonephrosis, bilateral	2 yrs. +
Due to:	
Other Conditions: Benign Prostatic Hypertrophy (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: Pyonephrosis, bilateral

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Asher Hollander M. D.
Address Sinai Hospital Date signed 4/26/47

V S 150

123a

G51140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

Registered No. G51140

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1533 Holbrook St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1533 Holbrook St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Stango Vernago

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband~~ or wife: Rose M. Vernago

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 9th 1892

8. AGE: Years	Months	Days	If less than one day
55	1	18	....hr. ....min.

9. Birthplace: Bulgaria (Town, county, and state)

10. Usual Occupation: Engineer

11. Industry or business: Md. Water Co

FATHER
12. Name: Unknown Vernago
13. Birthplace: Unknown

MOTHER
14. Maiden Name: "
15. Birthplace: "

16 (a) Informant: Mrs. Rose M. Vernago
(b) Address: 1533 Holbrook St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 4/30/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~: Morland Park
Location: Parkville Md.

18 (a) Funeral director: William Cook Jus.
(b) Address: 1217 St. Paul St.

19 (a) APR 28 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27th 1947, at ....M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946, to 4/27 1947, and that I last saw ~~him~~ alive on 4/27 1947.

Immediate cause of death	Duration
Carcinoma of Lung.	10 Mo.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ....at ....M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: S.L. Smith M. D.
Address: 1223 E. North Date signed 4/28/47

51141

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

✓ G51141

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division st.
(c) Hospital or institution: President Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 39 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 24 W. Lafayette Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Lawson

3 (b) If veteran, name war #2

3 (c) Social Security Account No. ?

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7, 1892

8. AGE: Years 54 | Months 10 | Days 18 | If less than one day hr. min.

9. Birthplace Lexington, Virginia (Town, county, and state)

10. Usual Occupation Truck driver

11. Industry or business

FATHER
12. Name George W. Lawson
13. Birthplace Lexington, Virginia

MOTHER
14. Maiden Name Phoebe Porter
15. Birthplace Rockbridge, Co., Virginia

16 (a) Informant George F. Lawson
(b) Address 24 W. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/28/47 (month) (day) (year)
(c) Cemetery or crematory Balto. Nat
Location Md.

18 (a) Funeral director Leg. H. Kelson
(b) Address 1303 Pleasant St. Huntington Williams, Md.

APR 28 1947 (Date rec'd by registrar)

VB 180

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 1947, at 6:?? PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-17- 1947, to 4-25-1947, and that I last saw him alive on 4-25 1947.

Immediate cause of death: Pulmonary Edema — Duration

Due to Cardio Vascular Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address Provident Hospital Date signed 4/26/47

X

G51142 BARCLAY

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G51142

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 425 Hawthorne Rd
(c) Hospital or institution: at home ?
(d) Length of stay in hospital or inst. (yrs., mos., or days) at home
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 425 Hawthorne Rd
(If rural, give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) **FULL NAME** McKee Barclay

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Helen D. Barclay

6 (c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.) August 8 1869

8. AGE: Years 77 | Months 8 | Days 18 | If less than one day: hr. min.

9. Birthplace Bee Wee Valley - Ky.
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business none

FATHER
12. Name Thos. P Barclay
13. Birthplace Kentucky

MOTHER
14. Maiden Name Louisa Rhoer
15. Birthplace Kentucky

16 (a) Informant Wm. Hugh M. Barclay (son)
(b) Address Ruxton - Balto 4

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr-28-47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville - Balto 8

18 (a) Funeral director Stewart Morris Co.
(b) Address 1 E Mount Ave.

19 (a) APR 28 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 1947, at 7 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946, to April 1947, and that I last saw him alive on April 26 1947.

Immediate cause of death	Duration
Broncho-pneumonia	5 days
Due to	
Due to	
Other Conditions: Arteriosclerotic Cardio-vascular-renal disease	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William G Reifsnyder M. D.
Address 5006 Reland Ave Date signed April 27 1947

VS 150

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G51143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G51143 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3406 Mondawmin Ave.
(c) Hospital or institution:
None
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3406 Mondawmin Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE K. SEMPELES

3 (b) If veteran, name war: Balkan Wars
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Basileke Sempeles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 26, 1878

8. AGE: Years	Months	Days	If less than one day
68	5	24	hr. min.

9. Birthplace: Karitsa, Sparta Greece
(Town, county, and state)
10. Usual Occupation: Store Keeper
11. Industry or business

FATHER
12. Name: Konstantine Sempeles
13. Birthplace: Greece

MOTHER
14. Maiden Name: Lillian
15. Birthplace: Greece

16 (a) Informant: George Sempeles, Jr.
(b) Address: 3406 Mondawmin Ave.

17 (a) Burial (b) Date thereof April 28, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory: Lorraine Park
Location: Baltimore, Md.

18 (a) Funeral director: Lambros Funeral Home, Inc.
(b) Address: 440 E. North Ave.

19 (a) Date received by registrar: APR 28 1947 (b) Registrar: Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1947 at 9.30 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 4 1947 to April 24th 1947. and that I last saw him alive on April 24 1947.

Immediate cause of death: Coronary Embolism. — Duration: sudden

Due to: Coronary Occlusion — 2 days

Due to: Coronary Vascular Disease — 3-4-47 & 4-24-47 attended

Other Conditions: Anemia Hypertension

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Thomas Graham Martin M. D.
Address: 516 Cathedral Date signed 4-28-47

X

G51144 BALTIMORE CITY HEALTH DEPARTMENT G51144
Registered No.

CERTIFICATE OF DEATH 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1409 Argyle Ave
(c) Hospital or institution: 14

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1409 Argyle Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William J. Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Nellie V. Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31, 1866

8. AGE: Years 81 | Months 10 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Waiter.

11. Industry or business

FATHER
12. Name William J. Smith
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Olivia Smith
15. Birthplace Baltimore Md.

16 (a) Informant Pauline Forrest
(b) Address 1607 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 28 1947
(month) (day) (year)
(c) Cemetery or crematory Arbutus Cemetery
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St Huntington Williams, Md.

(Date received by registrar) 1947 (Registrar)

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MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1947, at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J Pelham M.D.
Medical Examiner.
Date signed April 25, 1947

X

Please write the causes of death clearly and legibly.

G51145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

74a

G51145
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave & Madison St.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Hartford
(c) City or town Bel Air
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Weaver Danenhower

3 (b) If veteran, name war: World #1

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Iva May Danenhower
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 22 Aug 1843

8. AGE: Years 53 | Months 8 | Days 5 | If less than one day ... hr. ... min.

9. Birthplace Washington, D.C.
(town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name W.W. Danenhower
13. Birthplace Chicago, Ill.

MOTHER
14. Maiden Name Sally Mae Grant
15. Birthplace Washington, D.C.

16 (a) Informant Mrs. Adelaide Grant
(b) Address Belair, Md.

17 (a) Removal (b) Date thereof 4/30/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rock Creek Cem.
Location Wash., D. C.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

4/28 1947 (b) Huntington Williams M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 April 1947, at 5:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 Apr 1947, to 27 Apr 1947, and that I last saw h[illegible] alive on 27 Apl 1947.

	Duration
Immediate cause of death: Acute Myelogenous Leukemia	4 months
Due to:	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. Allan Spies M.D.
Address Md. Gen. Hosp. Date signed 27 Apl 47

X

G51146 BALTIMORE CITY HEALTH DEPARTMENT G51146
CERTIFICATE OF DEATH 33a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3408 Old Yorkd Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3408 Old Yordk Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian May Milburn (LILLIAN (Lillie) May Milburn

3 (b) If veteran, name war

3 (c) Social Security Account No. 049-01-0536

MEDICAL CERTIFICATION

3 (d) DATE OF DEATH April 27, 1947, at 10:35 A.M.

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife None

6 (c) If alive, give age years

21. I certify that death occurred on the date above stated, that I attended deceased from April 1 1947 to April 27 1947, and that I last saw her alive on April 26 1947.

7. Birth date of deceased (mo., day, yr.) Oct. 31, 1869

8. AGE: Years 77 Months 5 Days 26 If less than one day hr. min.

Immediate cause of death (a) Bronchial Pneumonia — Duration 7 days
Due to (b) Influenza — Duration 3 days
Due to (c)
Other Conditions Age — Duration
(Include pregnancy within 3 months of death)

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Retired Clerk

11. Industry or business Black Elec. Co.

FATHER 12. Name John Milburn
13. Birthplace Maryland

MOTHER 14. Maiden Name Mary Jane Fairbanks
15. Birthplace Baltimore Md.

16 (a) Informant Mrs Wardell Valentine
(b) Address 3408 Old Yorkd Rd

PHYSICIAN
Underline the cause to which death should be charged statistically.

Date of operation
Major findings of operation:
Autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

17 (a) Burial (b) Date thereof 4/29/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date rec'd by reg. APR 28 1947 (b) Registrar Washington Williams, M.D.

23. Signature [illegible] M.D.
Address [illegible]

VS 150

G51147

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 48 B

G51147 Registered No.

Please write clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution: University Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1616 Bolton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Henrietta) Etta C. Feldhaus -

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	215-03-4785

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife -- 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3, 1883

8. AGE: Years	Months	Days	If less than one day
63	9	23	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation -
11. Industry or business

FATHER
12. Name Frederick Feldhaus
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Fannie Randall
15. Birthplace -

16 (a) Informant Mrs. Alma H. Bailey
(b) Address 1616 Bolton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/29/47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

APR 28 1947 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/26 1947, at 12 55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/10 1947, to 4/26 1947, and that I last saw her alive on 4/24 1947.

Immediate cause of death Generalized Carcinoma - Dehydration & Malnutrition — Duration

Due to — Duration

Due to — Duration over

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George G. Massenburg M. D.
Address University Hosp. Date signed 4/26/47

VS 150

G51148

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G51148 Registered No. 1312a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2075 Rockrose Ave.
(c) Hospital or institution:
Ardley Nursing Home 9-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 606 Wyanoke Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDNA D. F. MORRILL

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Separated

6 (b) Name of husband or wife Burt Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept. 22, 1866

8. AGE: Years	Months	Days	If less than one day
80	7	4	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Fort
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Emma Cassidy
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Robert C. Morrill
(b) Address 3100 Clifton Ave.

17 (a) Removal (b) Date thereof 4/29/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location New London, Pa.
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.
19 (a) APR 28 1947 Huntington Williams, M.D. Registrar
(Date received) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26, 1947 at 3:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1 1946 to 4/25 1947.
and that I last saw h e alive on 4/24 1947.

Immediate cause of death Heart Failure — Duration 24 hrs.
Due to Left Cerebral Hemiplegia — 4 Days.
Due to Hypertensive Cardio Renal Vascular Disease — 10 yrs.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leherle C. Morrill
Address 7301 York Rd. Date signed 4/29/47
Towson

VS 150

G51149

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G51149 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Wyman Park Apts (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Albert WINTON Perkins

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Isabelle Wilson Perkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 26 1873

8. AGE: Years	Months	Days	If less than one day
73	7	1	hr. min.

9. Birthplace Texas (Town, county, and state)
10. Usual Occupation newspaper editor
11. Industry or business News-Post, Balto., Md.

FATHER
12. Name John Perkins
13. Birthplace Texas

MOTHER
14. Maiden Name Susan Wilson
15. Birthplace Arkansas

16 (a) Informant Mrs. Albert W. Perkins
(b) Address Wyman Park Apts Balto

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 4-29-47 (month) (day) (year)
(c) Cemetery or crematory Greenmount Crem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date rec'd by registrar 4-30-1947 (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/27/47 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h alive on 19 .

Immediate cause of death	Duration
Hypertensive cardio vascular disease	2 yrs
Due to	
Due to	
Other Conditions Heart block / Bronchopneumonia (Include pregnancy within 3 months of death)	4 yrs 2 wks

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman R. Freeman M.D.
Address Union Memorial Hosp Date signed April 27, 47

VS 150

G51150

BALTIMORE CITY HEALTH DEPARTMENT G51150 Registered No.

CERTIFICATE OF DEATH 94a

Please write clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 333 N. Charles St.
(c) Hospital or institution: 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 333 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PHOEBE JANE BIGGS

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	212-03-1842

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife –
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 12, 1886

8. AGE: Years	Months	Days	If less than one day
60	9	15	hr. min.

9. Birthplace Rocky Ridge, Md.
(Town, county, and state)
10. Usual Occupation Secretary
11. Industry or business Harrison Commission Co.

FATHER
12. Name Wm. H. Biggs
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Belle Anders
15. Birthplace Md.

16 (a) Informant Dr. Webster H. Brown
(b) Address 1034 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/29/47 (month) (day) (year)
(c) Cemetery or crematory Rocky Ridge Cem.
Location Union Bridge, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

R 28 1947 (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 27, 1947, at 4:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/11 1947 to 4/27 1947, and that I last saw her alive on 4/13 1947.

Immediate cause of death	Duration
Coronary Sclerosis & Thrombosis	Few hours
Due to Arterial & Hypertension	5 yrs.
Due to Angina	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lenard Morrison M. D.
Address 11 E. Chase St Date signed 4/28/47

VS 150

(2) X

G51151 ~~Liber~~ 10165 — BALTIMORE CITY HEALTH DEPARTMENT — CERTIFICATE OF DEATH — 89a — G51151 Registered No.

Please answer questions in ink. Write plainly with pen or pencil. Do not use abbreviations. If unknown, or not applicable, write none.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green St.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 911 Lemmon St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Phyllis M. Drury

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 22nd 1944

8. AGE: Years	Months	Days	If less than one day
2	7	5	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Oliver J. Drury
13. Birthplace St. Marys Co. Md.

MOTHER
14. Maiden Name Hilda L. Armstrong
15. Birthplace Baltimore, Md.

16 (a) Informant Mr Oliver J. Drury
(b) Address 911 Lemmon St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/29/47 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem.
Location 2930 Frederick Rd.

18 (a) Funeral director John J. Gowan & Son
(b) Address 901-03 Hollins St.

28 1947 (Date filed by registrar) Wellington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. **DATE OF DEATH** 4-27-47 1947, at 10 30/ M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-27 1947 to 4-27 1947 and that I last saw h Or alive on 4-27 1947

Immediate cause of death	Duration
Meningitis	
Due to Chronic otitis media	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gerald A. Martin M. D.
Address Univerisity Hospital Date signed 4-27-47

VS- 150

X

G51152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30a

Registered No. G51152

Type or print plainly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1434 Covington St.
(c) Hospital or institution: 74
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1434 Covington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie E. Elliott

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Phillip S.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1886

8. AGE: Years	Months	Days	If less than one day
60	11	14	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation house wife
11. Industry or business

FATHER
12. Name William Strieter
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Ringsdorf
15. Birthplace Baltimore

16 (a) Informant Phillip S. Elliott
(b) Address 1434 Covington St.

17 (a) Burial (b) Date thereof 4/29/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave & Rose St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) APR 28 1947 (b) Huntington-Williams Mort Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-26 1947, at 9:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-4 1947, to 4-26 1947, and that I last saw h-- alive on 4-26 1947.

	Duration
Immediate cause of death Chronic Myocardial Degeneration	1 yr.
Due to Syphilis	?
Due to	
Other Conditions Tabes Dorsalis	6 mo.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature A. M. Fallod, M. D.
Address 207 Fort Ave. Date signed 4-28-47

VS 150

937

G51153

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 92a

Registered No. G51153

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 631 E. Clement Street. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME CLARENCE BURKE

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 217-01-3641

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Josephine H. Burke
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) March 8, 1884

8. AGE: Years 63 | Months 1 | Days 27 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Watchman in general
11. Industry or business

FATHER
12. Name James Burke
13. Birthplace Md

MOTHER
14. Maiden Name Caroline Davis
15. Birthplace Md.

16 (a) Informant Mrs Josephine H. Burke
(b) Address 631 E Clement St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 30, 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Balto. Md.

18 (a) Funeral director A. Howard Evans & Son
(b) Charles St

APR 28 1947

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27, 1947, at 12.45 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Aortic Stenosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D. (Medical Examiner.)
Date signed 4-28-47

G51154 Gladys Clark London G51154

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 58B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 916 Harlem Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gladys Clark London.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: black | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-14-06

8. AGE: Years	Months	Days	If less than one day
40	7	13	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name George Clark
13. Birthplace Md

MOTHER 14. Maiden Name Kate Jeffries
15. Birthplace Va

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 30 47 (month) (day) (year)
(c) Cemetery or crematory Mt. Jacobs Cem
Location Emma Gould Rd Md

18 (a) Funeral director Williams & Jackson
(b) Address 916 Penn ave

19 (a) APR 28 1947 (Date rec'd by Registrar) Hunstington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 19 49 at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h alive on 19 .

Immediate cause of death Rheumatic heart disease, active, with mitral stenosis, Duration
Due to cardiac enlargement and failure
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert C. Austrian M.D.
Address Johns Hopkins Hosp. Date signed 11 Apr 47

VS 150

G51155 TN. F64819 110152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 115c

Registered No. G51155

Duplicate of certificate of death carefully and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5611 Warbler Ct. Zone 24
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Aaron Chester

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 16th 1942

8. AGE: Years	Months	Days	If less than one day
4	4	9	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James Burton
13. Birthplace Va.

MOTHER
14. Maiden Name Evelyn Chester
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospital
(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 29, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location Brooklyn, Md.
18 (a) Funeral director Chas O. Wilson
(b) Address 1510 Orleans St
19 (a) APR 28 1947 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION A.M.

20. DATE OF DEATH April 25th 1947, at 11.47 M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 24th 1947 to Apr. 25 1947 and that I last saw him alive on April 25th 1947

Immediate cause of death Ventricular Fibrillation — Duration
Due to Ether Anesthesia
Due to
Other Conditions Undergoing Tonsillectomy
(Include pregnancy within 3 months of death)
Date of operation 4-25-47
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 4-25-47 at A.M
(c) Where did injury occur? Balto City Hospital (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Hospital While at work? No (Specify type of place)
(e) Means of injury Operating table, death [illegible]
23. Signature Donald H. Earl M. D.
Address City Hospitals Date signed 4-26-47

VS 150 TO BE APPROVED BY THE MEDICAL EXAMINER Earl L Royer M.D.

G51156

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G51156 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3823 Hudson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3823 Hudson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY L. LANGDON

3 (b) If veteran, name war ----------

3 (c) Social Security Account No. 212-14-3072B

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	M.

6 (b) Name of husband or wife G. Wallace Langdon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9 1874.

8. AGE: Years	Months	Days	If less than one day
73	2	17	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation House-Work
11. Industry or business At Home.

FATHER
12. Name ? Ferguson
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Md.

16 (a) Informant C. Wallace Langdon (Husband)
(b) Address 3823 Hudson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-29-47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Eastern Ave. Rd.

18 (a) Funeral director Charles S. Zeiler.
(b) Address 3605 Fait Ave.

19 (a) (b)
(Signature of registrar)

APR 28 1947 Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 19 , at 9:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-15- 1947, to 4-26- 1947, and that I last saw h alive on 4-26 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	1½ hrs
Due to Chr. arteriosclerosis	2
Due to Diabetes Mellitus	2
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. J. Landon M. D.
Address 3218 Eastern Av. Date signed 4-26-47

X

G51157

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43a

Registered No. G51157

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2060 E. Hoffman St
(c) Hospital or institution:
8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2060 E. Hoffman St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles H. Gilland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Catherine A. Gilland

6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) Oct. 10 - 1870

8. AGE: Years 76 | Months 6 | Days 16 | If less than one day ..... hr. ..... min.

9. Birthplace Balto Co. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name David Gilland
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Pruett
15. Birthplace Md.

16 (a) Informant Catherine A. Gilland
(b) Address 2060 E. Hoffman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 - 29 - 47 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Park
Location Taylor Ave.

18 (a) Funeral director Wm. C. Miller Inc
(b) Address 2435 E. Oliver St

19 (a) APR 28 1947 Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 - 26 - 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/ 1946, to 4/26 1947, and that I last saw h alive on 4/26 1947.

Immediate cause of death: Acute Cardiac dilation

Due to:

Due to: Arterial hemorrhage

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S. C. Fletcher

Address Md. Date signed 4/28/47 M. D.

VS 150

G51158

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G51158

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Lombard
(c) Hospital or institution: University Hosp 20 W 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mo 16d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1484 Brunswick
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Catherine Moerkam Moerkem

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Carl C Moerkam
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3 1888

8. AGE: Years	Months	Days	If less than one day
59	1	24	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Elmer Parrish
13. Birthplace Md.

MOTHER
14. Maiden Name Oliva
15. Birthplace Md

16 (a) Informant Mr Carl C Moerkam
(b) Address 486 L Brunswick St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 30 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3501 Frederick Ave

18 (a) Funeral director Harry H Wright
(b) Address Edmondson Ave

19 (a) APR 28 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-27 1947, at 4:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/11 1947 to 4/27 1947, and that I last saw her alive on 4/27 1947.

Immediate cause of death	Duration
(a) Coronary occlusion	
(b) Cerebral Hemorrhage	
(c) Arteriosclerosis	
Due to (d) Pneumonia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George J Moscarillo M.D.
Address University Hosp Date signed 4/28/47

VS 150

5 L159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Register No. 51459

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor & Cleveland
(c) Hospital or institution: West Baet. more Gen Hosp 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1802 Raynor Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nina Crayton. (Nina Mackall Crayton)

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-05-1455

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	Married

6 (b) Name of husband or wife alvin J
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 4 1883

8. AGE: Years	Months	Days	If less than one day
63	6	21	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Home maker
11. Industry or business

FATHER
12. Name [redacted]
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Corrine Chew
15. Birthplace Baltimore Md

16 (a) Informant alvin J Crayton
(b) Address 3033 Edmondson Ave

17 (a) Buried (b) Date thereof April 29 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem
Location Dorsey Md

18 (a) Funeral director Harry H Wetzler
(b) Address 410 Edmondson Ave

19 (a) APR 28 1947 (b) Filed by Huntington Williams, M.D.
(Date filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 April 1947 at 11:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8 April 1947, to 25 April 1947, and that I last saw h[illegible] alive on 25 April 1947.

Immediate cause of death	Duration
Congestive Heart Failure	
Due to Massive Pul. Embolus	
Due to Phlebothrombosis	
Other Conditions Congestive Failure, Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lester J. Hall Jr. M.D.
Address West Baeto Gen Hosp Date signed 4/28/47

VS 150

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G51160

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G51160 Registered No. 170c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 min.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Carney
(If outside city or town limits, write RURAL and give town)
(d) Street No. Ridgeroad
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME GEORGIA A. McDANIELS

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Wm. P. McDaniel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13, 1882

8. AGE: Years	Months	Days	If less than one day
64	10	14	hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown Hudson
13. Birthplace Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Cecile L. Simone
(b) Address 7540 Belair Rd., Balto. 6, Md.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Apr. 30, 1947 (month) (day) (year)
(c) Cemetery or crematory Moreland
Location Balto., Md.

18 (a) Funeral director Lansdale Funeral Home
(b) Address 7401 Belair Road
(c) R 28 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27, 1947, at 12.40 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock due to fracture of all ribs, anteriorly, fractured pelvis

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-26-47 at 11 p. M. Balto. Co.
(b) Where did injury occur? Belair Rd. & Putty Hill
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Auto & auto collision

23. Signature Earl L. Royer M.D.
Medical Examiner.
Date signed 4-28-47

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G51161 BALTIMORE CITY HEALTH DEPARTMENT G51161

CERTIFICATE OF DEATH 1937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 425 N Pine St
(c) Hospital or institution:
17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 425 N Pine St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Adams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Cordelia Adams

6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) May 1, 1868

8. AGE: Years 78 | Months 11 | Days 27 | If less than one day ... hr. ... min.

9. Birthplace Mt Airy Md (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER 12. Name Samuel Adams

13. Birthplace ?

MOTHER 14. Maiden Name Henrietta Taylor

15. Birthplace Carroll Co Md

16 (a) Informant James W. Williams

(b) Address Mt Airy Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 1, 1937 (month) (day) (year)

(c) Cemetery or crematory Poplar Grove

Location Poplar Grove Church Cem

18 (a) Funeral director H. M. Engler

(b) Address Mt. Airy Md

19 (a) ... (Date rec'd by registrar) (b) ... Registrar

PR 28 1937 Huntington Williamsport, Md

Rev-6-50

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-28 1937, at 9 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-1- 1937 to 4-28-1937 and that I last saw h[illegible] alive on 4-23 1937.

Immediate cause of death	Duration
Hypertension	
Cardio Vascular	1 yr
Due to Disease	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Atwell Jones M. D.

Address 554 Dolphin St Date signed 4-28-37

X

51162 BALTIMORE CITY HEALTH DEPARTMENT G51162
BC# 668684 CERTIFICATE OF DEATH 64 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1513 N. Chapel St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1513 N. Chapel St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Edward KAUFMAN, Jr.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 23rd 1947

8. AGE: Years	Months	Days	If less than one day
	3	5	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Thomas E. Kaufman Sr.
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Ruth Hiser
15. Birthplace Balto. Md.

16 (a) Informant Thomas E. Kaufman Sr.
(b) Address 1513 N. Chapel St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 5/1/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto. " Md.
Location

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St

APR 29 1947 (Date rec'd by Registrar) (Signature) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28 1947, at 12:00 PM

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Status thymicolymphaticus

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 4/28/47

VS 181

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G51163 Registered No.

Please answer questions on death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 329 E. 20th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 329 E. 20th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jane G. Ehrman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Henry Ehrman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8th 1867

8. AGE: Years 79 | Months 9 | Days 18 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER 12. Name Charles Prunty

13. Birthplace Ireland

MOTHER 14. Maiden Name Anna C. Wilber

15. Birthplace Ireland

16 (a) Informant Henry Ehrman

(b) Address 329 E. 20th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/29/47 (month) (day) (year)

(c) Cemetery or crematory Balto.

Location " Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St.

APR 29 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26th 1947, at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1946 to April 26 1947 and that I last saw h. alive on April 26 1947.

Immediate cause of death	Duration
Myocardial Insufficiency	6 mos
Due to Cerebral Hypertension	6 mos
Due to Cerebral Arteriosclerosis	6 mos
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas F. White M. D.

Address 532-E 22nd St Date signed 4/28/47

X

51164

BC# B76665

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G51164

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution JOHNS HOPKINS HOSPITAL 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1831 W. Franklin Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME McTeer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Black

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22, 1947

8. AGE: Years | Months | Days | If less than one day 2 hr. 5 min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles J. McTeer
13. Birthplace Unknown

MOTHER
14. Maiden Name Minuette Clark
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo APR 28 1947

18 (a) Funeral director Commissioner of Health
(b) Address

APR 29 1947 (Signature of Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1947, at 1:45A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 22 1947 to April 23 1947 and that I last saw him alive on April 23 1947

Immediate cause of death	Duration
Prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Russell Jordan M. D.
Address Johns Hopkins Hospital Date signed 4-23-47

VS 150

51165 BC# B76288

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

G51165 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DEACEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 12 N. Stricker (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Williams

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/16/47

8. AGE: Years	Months	Days	If less than one day
			10 hr. min.

9. Birthplace md. (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER 12. Name Philo Kelyard
13. Birthplace Unknown

MOTHER 14. Maiden Name Madelyn Williams
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo APR 28 1947
18 (a) Funeral director Commissioner of Health
(b) Address
19 APR 29 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1947, at 5. A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 16 1947, to April 17 1947 and that I last saw him alive on April 17 1947.

Immediate cause of death Atelectasis — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George S Palmer
Address Johns Hopkins Hosp Date signed 4-25-47

VS 150

1166 BC# 376681

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160c

G51166 Registered No.

Type or print plainly and legibly. Use ink. Do not write over dotted lines.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Sail Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Busby

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21, 1947

8. AGE: Years	Months	Days	If less than one day
		2	12 hr. 15 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER: 12. Name Albert Busby
13. Birthplace Unknown

MOTHER: 14. Maiden Name Helen Rose
15. Birthplace West Virginia

16 (a) Informant Hospital Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Johns Hopkins Medical Schoo

18 (a) Funeral director
(b) Address

19 APR 29 1947 (Date received by Registrar) Registrar

APR 28 1947 Commissioner of Health

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1947, at 2:10 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 21 1947 to April 23 1947, and that I last saw him alive on April 23 1947.

Immediate cause of death	Duration
Intra uterine anoxia	
Due to Occult prolapse of cord associated with double	
Due to footling breech.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Russell Jordan M. D.
Address Johns Hopkins Hospital Date signed 4-23-47

VS 150

51167

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G51167 Registered No.

BH 43-76835 160a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Howard
(c) City or town Ellicott City
(If outside city or town limits, write RURAL and give town)
(d) Street No. Folly Quarters Farm
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kemp

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23, 1947

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Samuel Kemp
13. Birthplace Unknown

MOTHER
14. Maiden Name Stella Geiger
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo

18 (a) Funeral director
(b) Address

APR 29 1947 (Date rec'd by Registrar)

Commissioner of Health
[signature] M.D.
Registrar

APR 28 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1947 at 9:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 23 1947 to April 24 1947, and that I last saw him alive on April 24 1947.

Immediate cause of death	Duration
Intracranial injuries	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B C Williams MD

Address Johns Hopkins Hospital Date signed 4-24-47

VS 150

X

51168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 051168

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring & Belvieu Aves
(c) Hospital or institution:
Lyndale Hebrew Home - Inf 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2115 Pressbury St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SOLOMON YAKER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Late Rebecca

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years 74 Months Days If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

MOTHER | FATHER

12. Name Isaac Yaker

13. Birthplace Russia

14. Maiden Name Unkown

15. Birthplace Russia

16 (a) Informant Morris Yaker

(b) Address 2907 Norfolk Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 29, 1947 (month) (day) (year)

(c) Cemetery or crematory Maryland Lodge Cem

Location Hebrew Rosedale Cem

18 (a) Funeral director Sol Levinson & Bros

(b) Address 1124 1126 W North Ave

19 APR 29 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-28 1947; at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from October 1941 to 4-28 1947 and that I last saw h(er) alive on 4-28 1947

Immediate cause of death: Cerebral hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Henry Nagel M. D.

Address Lyndale Home Date signed 4-28-47

VS 150

X

651169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 651169

Please write plainly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 635 W. Hoffman St.
(c) Hospital or institution:
17
(d) Length of stay in hospital or inst., (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 635 W. Hoffman St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROSA McGEE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife Jeremiah McGee
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15, 1879

8. AGE: Years	Months	Days	If less than one day
67	9	11	hr. min.

9. Birthplace Wilmington, N. C.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Able Jones
13. Birthplace Warsox, N. C.

MOTHER
14. Maiden Name Sarah Thomas
15. Birthplace Little Wash, N. C.

16 (a) Informant Mr. Jeremiah McGee
(b) Address 635 W. Hoffman St.

17 (a) Burial (b) Date thereof 4-28-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery Cem.
Location Anne Arundel, Co., Md.
18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.
19 (a) APR 29 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 19 47 at 6:30 M
21. I certify that death occurred on the date above stated; that I attended deceased from Dec 17 1947 to April 26 1947 and that I last saw h alive on April 26 1947.

Immediate cause of death	Duration
Carcinoma Vesicle Urethra	1 yr.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Wm. H. Williams M.D.
Address 5154 Brighton Date signed April 29 1947

VS 150

C51170

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. C51170

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1327-N. Eden St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1327- N. Eden St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country No.

3 (a) **FULL NAME** Alice Margaret Valentine

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12, 1883

8. AGE: Years 64 | Months 1 | Days 15 | If less than one day hr. min.

9. Birthplace North Carolina (Town, county and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Eaton Harrison
13. Birthplace North Carolina

MOTHER
14. Maiden Name unknown
15. Birthplace North Carolina

16 (a) Informant Mary E. Stokes
(b) Address 1327 N. Eden St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/30/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemet.
Location Edgar Hill Rd.

18 (a) Funeral director A. Foreman
(b) Address 918 Druid Hill Ave.

19 (a) APR 29 1947 (Date received) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27, 1947 at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 25 1947 to April 27 1947 and that I last saw him alive on April 27 1947.

Immediate cause of death: Cerebral Hemorrhage — Duration 7

Due to: Hypertension

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. B. Stewart M. D.
Address 624 Fremont Ave. Date signed 4/29/47

VS 150

G51171

JL - 110148

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 74a

G51171

Registered No.

Please answer questions on death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 917 Bennett Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Rowan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 24, 1918

8. AGE: Years	Months	Days	If less than one day
29	3	4	hr. min.

9. Birthplace N. C.
(Town, county, and state)
10. Usual Occupation Hair Dresser
11. Industry or business

FATHER
12. Name Ollie Rowan
13. Birthplace N. C.

MOTHER
14. Maiden Name Lucy Jane Jackson
15. Birthplace N. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 4/30/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Southern Pine N.C.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 APR 29 1947 (b) Huntington Williams, M.D.
(Registered by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28 19 47, at 8.25A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 25 19 47, to April 28 19 47, and that I last saw h[illegible] alive on April 28 19 47.

Immediate cause of death	Duration
Circulatory Failure	
Due to Probable Lymphatic Leukemia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. P. Barbarosa
Address Balto. City Hosp. Date signed 4-28-47
M. D.

X

G51172

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

Registered No. G51172

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) 9

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town New York City
(If outside city or town limits, write RURAL and give town)
(d) Street No. Hotel Seville N.Y.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas M. Godrich

3 (b) If veteran, name war ?

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-19-85

8. AGE: Years	Months	Days	If less than one day
62	0	8	hr. min.

9. Birthplace California (Town, county, and state)

10. Usual Occupation Civil Engineer

11. Industry or business

FATHER 12. Name William W Goodrich

13. Birthplace N.Y.

MOTHER 14. Maiden Name Maria Mac Tenathan

15. Birthplace N.Y.

16 (a) Informant Thomas M. Goodrich

(b) Address 1319 Bolton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 30/47 (month) (day) (year)

(c) Cemetery or crematory Greenmount

Location North Ave. & Greenmount ave

18 (a) Funeral director John D. Mitchell & Son

(b) Address 1900 Eutaw Place

19 (Date received by registrar) APR 29 1947 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-27- 1947, at 5:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-19- 1947, to 4-27 1947, and that I last saw h[illegible] alive on 4-27 1947.

	Duration
Immediate cause of death Coronary thrombosis	7 days
Due to Arteriosclerotic heart disease	3
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward H. Jones Jr. M. D.

Address Union Mem. Hosp. Date signed 4-27-47

VS 150

G51173

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. G51173

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 108 W. Heath St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 108 W. Heath St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert W. Dehn

3 (b) If veteran, name war #1

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lillian
6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) Nov 25, 1900

8. AGE: Years	Months	Days	If less than one day
46	5	-	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Truckster
11. Industry or business Self

FATHER
12. Name Wm Dehn
13. Birthplace Md.

MOTHER
14. Maiden Name Maggie Slouch
15. Birthplace Md

16 (a) Informant Mrs Lillian Dehn
(b) Address 108 W. Heath St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/29/47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd

18 (a) Funeral director John F Henry Inc
(b) Address 115 Light St

19 (a) APR 29 1947 (b) Huntington Williamsport, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 1947 at 7:30 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 13, 1947 to 4-5 1947 and that I last saw him alive on Apr. 25, 1947

Immediate cause of death Rheumatic heart disease — Duration 2

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Deckel M. D.
Address 1226 Hanover St Date signed 4/26/1947

X

G51174

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

G51174 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3006 Barclay St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 54 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3006 Barclay St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel V. Bordley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Arthur W. Bordley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 30, 1892

8. AGE: Years	Months	Days	If less than one day
54	4	27	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John C. Weil
13. Birthplace Baltimore Co., Md.

MOTHER
14. Maiden Name Irene Stritehoff
15. Birthplace Baltimore Co., Md.

16 (a) Informant Arthur W. Bordley
(b) Address 3006 Barclay Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/29/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Balto. Co., Md.
18 (a) Funeral director Governeur W. Love
(b) Address 805 N. Calvert St.
19 (a) APR 29 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 April 1947 at 8:45 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 26 April 1947 to 27 April 1947, and that I last saw h.e. alive on 26 April 1947.

Immediate cause of death	Duration
Carcinoma of Fundus of Uterus with generalized	1 yr.
Due to abdominal metastasis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Wm. H. Kammerer Jr.
Address 70 Sheridan Ave. Date signed 28 April

VS 150

X

G51175

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G51175 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 911 South Fell St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George E Sackett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace Mass. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Sackett
13. Birthplace Mass.

MOTHER 14. Maiden Name
15. Birthplace —

16 (a) Informant Mrs. Sadye Stamalos
(b) Address 911 Fell St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-30-1947 (month) (day) (year)

(c) Cemetery or crematory St Matthews
Location Old Orchard St Cat.

18 (a) Funeral director Leo S. Leach
(b) Address 1701-03 N. Patterson Park Ave

19 (a) APR 29 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/26/47 19 , at 7:55 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Devereux, M.D. Medical Examiner.
Date signed 4/27/47

G51176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G51176 Registered No.

Type or use ink. Spell out full name of deceased. Do not abbreviate. Write clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1355 Andre St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1355 Andre St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Pauline Klemmick.
3 (b) If veteran, name war
3 (c) Social Security Account No. 218-22-9209

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife August Klemmick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 28th 1885

8. AGE: Years	Months	Days	If less than one day
61	4	30 29	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Martin Rends.
13. Birthplace Unknown.

MOTHER
14. Maiden Name Margaret O'White.
15. Birthplace England.

16 (a) Informant George Klemmick.
(b) Address 1423 Beason St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/1/47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location A A County

18 (a) Funeral director Charles F. Dill
(b) Address 1501 E Fort Ave.

19 (a) APR 29 1947 (Date rec'd by registrar) (b) Huntington Williamson, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 1947 at 5P. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 22 1947 to April 27 1947 and that I last saw h e alive on April 27 1947.

Immediate cause of death	Duration
Bronchopneumonia	2d
Cerebral Hemorrhage	4d
Due to Arterio Sclerosis	6d
Hypertension	6d.
Due to Gen. Arteriosclerosis Nephritis	6d.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature F F A Stevens M. D.
Address 2878 Harford Rd Date signed 4-28-47

VS 150

G51177

BALTIMORE CITY HEALTH DEPARTMENT ✓ G51177
Registered No.

CERTIFICATE OF DEATH 46B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4300 Evans Chapel Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4300 Evans Chapel Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL C. MILNER

3 (b) If veteran, name war: -
3 (c) Social Security Account No.: -

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bertha Milner (nee Price)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28, 1865

8. AGE: Years 81 | Months 8 | Days 29 | If less than one day hr. min.

9. Birthplace Catchelville, Pa. (Town, county, and state)
10. Usual Occupation -
11. Industry or business

FATHER
12. Name Nathan Milner
13. Birthplace Pa.

MOTHER
14. Maiden Name Ann McCleneyham
15. Birthplace Ireland

16 (a) Informant Mrs. Bertha Milner
(b) Address 4300 Evans Chapel Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/30/47 (month) (day) (year)
(c) Cemetery or crematory Maryland Line Cem.
Location Maryland Line, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) APR 29 1947 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1946 to April 27 1947; and that I last saw him alive on April 27 1947.

Immediate cause of death: Ca. Stomach
Due to: generalized carcinomatosis

Duration
?

Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lawrence A. Slemaker M.D.
Address 3711 Daily Rd. Date signed 4-28-47

VS 150

X

G51178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

MAY 7 1947

Registered No. G51178

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1602- E. Preston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOSEPH FOOTE

3 (b) If veteran, name war: W. W # 2

3 (c) Social Security Account No.: ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/18/1926

8. AGE: Years	Months	Days	If less than one day
20	10	9	hr. min.

9. Birthplace md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Joseph Foote
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Johnson
15. Birthplace Md

16 (a) Informant Joan Foote
(b) Address 1404 Eutaw St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/1/47 (month) (day) (year)
(c) Cemetery or crematory Balto. Nat. Location Md.

18 (a) Funeral director Geo. H. Kelagg
(b) Address 1363 Eutaw St

19 (a) APR 29 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27, 1947, at 10.55 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Bullet-wound of heart, liver, and Kidney.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-26-47 at 10.35 p. M.
(b) Where did injury occur? 1030 N. Gay Street.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Firearms

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 4-28-47

VS 181

write the cause of death clearly and legibly.

51179 TB. 38278

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45F

G51179 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8- 6- 3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 404 W. Camden St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Gates

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: ?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years 54 ? | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 30/47 (month) (day) (year)
(c) Cemetery or crematory Mount Olivet
Location Washington D.C.

18 (a) Funeral director Wm. J. Fenton's Sons
(b) Address Pratt + Pleasant Aves

19 APR 29 1947 (Registered by) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25th 19 47 at 3.00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 22/ 19 38 to Apr. 25 19 47 and that I last saw h im alive on Apr 25 19 47

Immediate cause of death: Carcinoma of pharynx — Duration 18 mo.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Carcinoma of pharynx

Autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Hobbs

Address Balto. City Hosp. Date signed 4/29/47 M. D.

G51180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 1a

Registered No. G51180

Type or use ink. Fill all items. Write cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 913 E. Chase St.
(c) Hospital or institution: 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 913 E. Chase St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick J. Ruppel

3 (b) If veteran, name war: No.

3 (c) Social Security Account No. No

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Louise M. Ruppel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 3, 1866

8. AGE: Years 80 | Months 6 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Retired Carpenter

11. Industry or business

FATHER
12. Name John Ruppel
13. Birthplace Germany

MOTHER
14. Maiden Name Not Known
15. Birthplace Germany

16 (a) Informant Mrs. Louise Ruppel
(b) Address 913 E. Chase St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 1, 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location 4430 Belair Rd.

18 (a) Funeral director Elmer W. Castelin & Son
(b) Address 2144 E. Eager St.

19 APR 29 1947 (Date rec'd by registrar) (b) Huntington Woods, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28, 1947 at 3:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1947 to April 28 1947 and that I last saw h[illegible] alive on April 23 1947

Immediate cause of death	Duration
Embolism	
Due to Cardiovascular renal disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jack J. Singer M.D.

Address 506 E. North Ave. Date signed 4-29-47

G51181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 ✓ Registered No. G51181

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) dod
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 215 S. Paca St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Frank Stanton or Stankevich

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Not known ?

8. AGE: Years 41 | Months | Days | If less than one day .....hr. .....min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Charles Stanton
13. Birthplace Russian ?

MOTHER
14. Maiden Name Otillie ?
15. Birthplace Baltimore Md

16 (a) Informant Mrs. Otillie Stanton
(b) Address 215 S. Paca St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 30-47 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Dundalk Avenue

18 (a) Funeral director John A. Grebhauckas Jr.
(b) Address 423 S. Paca St
Huntington Williams Mgr.

APR 29 1947 (Date received by Registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26, 1947, at 4 50 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Lie death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration
Fatty Degeneration ?

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at ..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
Means of injury.....

23. Signature Earl L. Royer M.D. (Medical Examiner.)
Date signed 4-28-47

G51182 ✓ G51182

BALTIMORE CITY HEALTH DEPARTMENT

Registered No.

CERTIFICATE OF DEATH 131a

Type or use ink. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2059 W. Lombard St.
(c) Hospital or institution: VO
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2059 W. Lombard St
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Italy

3 (a) FULL NAME Giovannina Palacendo

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Vincent
6 (c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) June 8-1881

8. AGE: Years 65 | Months 7 | Days 19 | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Anthony Papa
13. Birthplace Italy

MOTHER 14. Maiden Name Katie Battaglia
15. Birthplace Italy

16 (a) Informant Mrs Mary Palacendo
(b) Address 525 N. Denison St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/21-1947 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem
Location Old Frederick Rd

18 (a) Funeral director Joseph Tavani Inc
(b) Address 2015 Rhemmount Ave

19 (a) (b)

APR 29 1947 Washington-Millington Mfg. Co.

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 27 1947 at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 9 1947, to Apr 27 1947, and that I last saw h.er alive on Apr. 27 1947

Immediate cause of death Cerebral Hemorrage — Duration 4/15/47

Due to Chr Myocarditis — 1945

Other Conditions Chr. Interstitial nephritis — 1945

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul E. Maus M. D.

Address 1663 N. North Ave Date signed 4/28/47

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G51183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G51183 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2538 Harford Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 27 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2538 Harford Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Antonina Mariannina Cimino

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Francesco Cimino

6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) May 10, 1871

8. AGE: Years 75 | Months 11 | Days 17 | If less than one day ######### min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Rosario Mileo
13. Birthplace Italy

MOTHER
14. Maiden Name
15. Birthplace Italy

16 (a) Informant Andrew Cimino (Son)
(b) Address 2538 Harford Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 1, 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd., Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) Date received APR 29 1947 (b) Huntington Williams, M.D. (Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27th 1947, at 9.10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 10 1947 to April 27 1947 and that I last saw h[illegible] alive on April 25 1947.

Intermediate cause of death: Uremia, Acid Insufficiency

Due to

Due to

Other Conditions: Arteriosclerosis, Hypertension, Diabetes
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Peter G. Schenuit, M. D.
Address 1337 S. Charles St. Date signed 4/29/47

V S 150

G51184

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46B

Registered No. G51184

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4029 FAIRFAX RD
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4029 FAIRFAX RD (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL BLUMBERG

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife FREDA

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
47			hr. min.

9. Birthplace HAVRE DE GRACE MD (Town, county, and state)

10. Usual Occupation MERCHANT

11. Industry or business

FATHER
12. Name ABRAHAM
13. Birthplace RUSSIA

MOTHER
14. Maiden Name IDA
15. Birthplace RUSSIA

16 (a) Informant WIFE
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4-30-47 (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh
Location Windsor Mill Rd

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto St

19 (a) APR 29 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-29-47 19..., at 5:30 P.M.

21. I certify that death occurred on the date above stated: that I attended deceased from Dec 23 19 46 to Apr 28 19 47 and that I last saw h.im. alive on Apr 28 19 47

Immediate cause of death Carcinoma of Stomach — Duration 1½ yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Nov., 1946

Major findings of operation: Cancer of Stomach

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Irwin Darter M. D.
Address 3003 Jamison, Md. Date signed 4-29-47

G51185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G51185 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2520 Shirley Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lena Rothenberg

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Abraham

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Victor
13. Birthplace Russia

MOTHER
14. Maiden Name Levi
15. Birthplace Russia

16 (a) Informant Husband
(b) Address

17 (a) Burial (b) Date thereof 4-30-47 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Ahavath Chesed
Location Wash. Blvd.

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto St

19 (a) APR 29 1947 (b) Huntington Williams
(Filed by Registrar)

V S-150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29, 1947, at 5:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 15, 1947 to April 29 1947, and that I last saw her alive on April 25, 1947.

Immediate cause of death	Duration
Cardiac failure	
Due to Arteriosclerotic heart disease	
Due to Generalized arteriosclerosis	
Other Conditions Abdominal tumor	over

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sidney Green M. D.
Address Sinai Hospital Date signed 4/30/47

X

G51186

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G51186

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. A. D.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1522 N. Pulaski Street (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Bores Tarsas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Pauline

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 68 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Moses
13. Birthplace Russia

MOTHER
14. Maiden Name Lung
15. Birthplace Russia

16 (a) Informant Pauline Tarsas
(b) Address 1522 N Pulaski St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-30-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phila Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 428 E Balto St

19 (a) APR 29 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28, 1947, at 1 05 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH..... Arteriosclerotic cardiovascular disease, with hypertension.

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 4/28/47

X

G51187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G51187

Type or print clearly and legibly. Use black ink. Do not write in shaded areas. Underline the cause of death.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 514 N. Potomac St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 514 N. Potomac St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna M. Felter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Christian Felter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20-1874

8. AGE: Years 72 | Months 11 | Days 7 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housework.

11. Industry or business

FATHER
12. Name John Wittig
13. Birthplace Germany.

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Mrs. Charles Baier
(b) Address 514 N. Potomac St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 1-47 (month) (day) (year)
(c) Cemetery or crematory St. Matthews Cem.
Location Donnell St.

18 (a) Funeral director John A. Miller
(b) Address 2334 Jefferson St.

19 (a) APR 29 1947 (Local registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-27 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to 4-27 1947, and that I last saw him alive on 4-27 1947

Immediate cause of death: Hypertension
Due to: Cardiac Dilation
Due to: Arteriosclerosis
Other Conditions:
(Include pregnancy within 3 months of death)

Duration
4 yrs

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Fred Ruppert M.D.
Address: 5009 Reisterstown Rd. Date signed: 4-28-47

VS 150

G51188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G51188

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hosp. 5W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22a
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1108 Lanvale St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Eva Mae (McCARDY) Wells McCoy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife James Wells
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5, 1912

8. AGE: Years	Months	Days	If less than one day
35	4	5 16	.....hr. .....min.

9. Birthplace Wayne Co. N.C. (Town, county, and state)
10. Usual Occupation Domestic.
11. Industry or business

FATHER
12. Name James Deas.
13. Birthplace Wayne Co. N.C.

MOTHER
14. Maiden Name Maggie J. Barnes
15. Birthplace Wayne Co. N.C.

16 (a) Informant Maggie J. Barnes
(b) Address Wilkesboro, N.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 29, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location.....

18 (a) Funeral director Mrs Kate R. Williams
(b) Address 322 N. Schroeder St.

19 APR 29 1947 (Date received by Registrar) (b) Huntington Northside, Md. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1947 at 4 45 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Atelectasis of rt. lung
Pulmonary tuberculosis

Due to.....

Other Conditions Scoliosis of spine

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 4/22/47

G51189

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G51189 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County Baltimore
(c) City or town Baltimore #38 Intervale
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2 Jones Avenue
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Harry HENRY HARRIS (Richard Henry)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1880

8. AGE: Years 66 | Months 4 | Days 28 | If less than one day .....hr. .....min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Richard Thomas Harris
13. Birthplace Md.

MOTHER 14. Maiden Name Josephine ?
15. Birthplace Md.

16 (a) Informant Bertie Harris Smith
(b) Address 131 Winters Lane

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 5-1-47 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Balto. Co.

18 (a) Funeral director Samuel N. Sullivan Jr.
(b) Address 1011 N. Arlington Ave

19 APR 29 1947 (b) Huntington Williamsport, Md.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/26/47, 19..., at 7:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Dr. Lyle R. Davis, M.D.
Medical Examiner.
Date signed 4/27/47

G51190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G51190 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4507 Liberty Heights Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 d
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4507 Liberty Heights Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Philippine H. Riddle

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Frank J. Riddle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22, 1873

8. AGE: Years	Months	Days	If less than one day
73	11 10	7	hr. min.

9. Birthplace Pittsburg, Pa.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Adam Hoffman
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Adams
15. Birthplace Germany

16 (a) Informant Mrs. Lewis O. Myhre
(b) Address 4507 Liberty Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 1, 1947 (month) (day) (year)
(c) Cemetery or crematory Church Hill Cemetery
Location Wilkens Township, Pa.

18 (a) Funeral director E. L. Tomarchio
(b) Address 4510 Liberty Heights Ave.

19 (a) APR 29 1947 (Date rec'd by registrar) (b) Tunstall Tom Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1947, at 12:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 9 1944 to April 29 1947. and that I last saw h e alive on April 29 1947.

Immediate cause of death
1) Arterio Sclerotic Heart Disease — Duration 5 yrs.
Due to
Due to
Other Conditions 2) Cerebral Hemorrhage. — Duration 2 yrs.
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Earl L. Chambers M. D.
Address 4106 Liberty Hts Date signed 4/29/47

5I191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. G5I191

Please write the facts of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 and A Calvert
(c) Hospital or institution:
Union Memorial Hosp. 11-7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Charles & Centre Sts
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs William MacDonald Veale) Blanche de P. Graham Veale

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 3 1876

8. AGE: Years	Months	Days	If less than one day
70	5	26	hr. min.

9. Birthplace St Louis Mo
(Town, county, and state)

10. Usual Occupation Mrs.

11. Industry or business

FATHER
12. Name Edward Luby Graham
13. Birthplace Balt. Md.

MOTHER
14. Maiden Name Louise Natalie
15. Birthplace Ill.

16 (a) Informant Mr Graham Veale
(b) Address Glyndon, Md.

17 (a) Buried (b) Date thereof Apr 30 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director Henry H. Jenkins Sons Co
(b) Address N. Gilmor & Orchard Sts

19 (a) APR 30 1947 (b) Registrar Williams M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-28 1947 at 10:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-27 1947 to 4-28 1947 and that I last saw h.e.p alive on 4-28 1947

Immediate cause of death Uraemia

Due to Ca cervix

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Ca - uterus

Duration
P
-

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George J. Jenkins M.D.
Address [illegible] Date signed 4/29/47

X

5[illegible]192 G5[illegible]192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. .....

Please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 422 S. Pulaski ST
(c) Hospital or institution: No

(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 422 S Pulaski ST
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Johanna Eisenmeier

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife late Albert
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 26 1865

8. AGE: Years	Months	Days	If less than one day
81	4	1	..... hr. ..... min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation .....
11. Industry or business .....

FATHER
12. Name Gattschalk
13. Birthplace Germany

MOTHER
14. Maiden Name Wiehe
15. Birthplace Germany

16 (a) Informant Mrs Anna R List
(b) Address 422 S Pulaski St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 30 '47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3201 Frederick Rd

18 (a) Funeral director Henry H. Gruber
(b) Address 4101 Edmondson Ave

19 (a) APR 30 1947 (Date filed by Registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 1947, at ..... M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-3 1947 to 4-27 1947
and that I last saw her alive on 4-27 1947

Immediate cause of death Hypertensive cardio vascular disease

	Duration
Due to —	
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature H. Tony Lederer M.D.
Address 1226 Hanover St Date signed 4-29-47

VS 150

X 47

51193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 651193

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 128 McPhail St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 222 Westshire Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Ryan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John P Ryan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 20, 1890

8. AGE: Years 56 | Months 8 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Christian Gunser
13. Birthplace Germany

MOTHER
14. Maiden Name Anna
15. Birthplace U. S. A.

16 (a) Informant Mrs John Ryan
(b) Address 222 Westshire Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 30 1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd

18 (a) Funeral director Harry A Wilhelm
(b) Address 4701 Edmondson Ave

APR 30 1947 Harrington Williams M.D. Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-8-47 19 to 4-22-47 19, and that I last saw he alive on 4-26-47 19

Immediate cause of death	Duration
Bronchial Carcinoma	
Due to Carcinoma of Lung	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry A Wilhelm M.D.

Address 703 Edmondson Ave Date signed 4-28-47

X

94

BALTIMORE CITY HEALTH DEPARTMENT ✓ Registered No. C51194

CERTIFICATE OF DEATH 50

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1214 Madison ave
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1214 Madison ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Pruden

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Col
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: George
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 11-16-1906

8. AGE: Years 40 | Months 5 | Days 13 | If less than one day hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation House Work

11. Industry or business

FATHER
12. Name Charles Rogers
13. Birthplace N. C.

MOTHER
14. Maiden Name Belle Branch
15. Birthplace

16 (a) Informant William Rogers
(b) Address 1214 Madison ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 / 1 / 47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location Baltimore Md

18 (a) Funeral director William A Jackson
(b) Address 916 Penna ave

APR 30 1947 (Date received) (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1947, at 12 40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 5, 1947 to April 29 1947, and that I last saw h[illegible] alive on April 29 1947.

Immediate cause of death	Duration
Cancer of breast (left) with Metastasis	One year
Due to — "	
Due to — "	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. M. Greenfield M. D.
Address 1821 Eutaw Pl Date signed 4/29/47

VS 150

G51195

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G51195 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Broadway
(c) Hospital or institution: Johns Hopkins Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County **********
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1619 Bolton Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No) NO
If yes, name country

3 (a) FULL NAME JULIA BARTLETT CHATTERLEY

3 (b) If veteran, name war: NONE
3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Douglas W. Chatterley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 26, 1900

8. AGE: Years	Months	Days	If less than one day
47	3	2	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Edward L. Bartlett, Jr.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mabel Mason
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Douglas W. Chatterley(husband)
(b) Address 1619 Bolton Street, Baltimore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 30-1947 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location Pikesville, Balto. Co., Md.

18 (a) Funeral director Stewart & Mowen Company
(b) Address 108 W. North Ave., Balto., Md.

19 (a) Filed (b) Registrar Huntington Williams M.D.
APR 30 1947

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 28 1947, at 12 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Atelectasis of left lung
Myocardial degeneration
Due to

Other Conditions Colloid adenoma of thyroid.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 4/29/47

5T196
AB-109760

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G5T196
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 3.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7days
(e) Length of stay in Baltimore (yrs., mos., or days) 29yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1616 E. Pratt Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Matthew Anthony McGee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept-2- 1887

8. AGE: Years	Months	Days	If less than one day
59	7	14	hr. min.

9. Birthplace Texas
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Matthew McGee, Sr.
13. Birthplace Ireland

MOTHER
14. Maiden Name Elizabeth Maroney
15. Birthplace Texas

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 4/30/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Govanstown Hill Rd

18 (a) Funeral director J. J. Speyer Sons
(b) Address 330 Eight St.

APR 30 1947 (Date rec'd by local registrar) (b) Livingston Williams M.D.

MEDICAL CERTIFICATION AM

20. DATE OF DEATH April 16 1947, at 4.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-9- 1947, to 4-16 1947, and that I last saw him alive on 4-16 1947

Immediate cause of death	Duration
Coronary Occlusion	2 hrs.
Due to Generalized Arteriosclerosis	
Due to	
Other Conditions Pyogenic Infection of Left Foot	

(Include pregnancy within 3 months of death)

Date of operation 4-12-47
Major findings of operation I. & D. Infected Left Foot
of autopsy Arteriosclerosis & Coronary Occlusion

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Butler M.D.
Address City Hospitals Date signed 4-24-47 M. D.

VS 150

X

G51197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G51197

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3211 Lindale Ave (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country Switzerland

3 (a) FULL NAME Henry Schluderberg

3 (b) If veteran, name war A — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of ~~husband or~~ wife Eleonore Hart
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Jan 8- 1884

8. AGE: Years	Months	Days	If less than one day
63	3	20	.....hr. .....min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation.....
11. Industry or business B&O. R. R. Camden Sta.

FATHER
12. Name Henry Schluderberg
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Platt.
15. Birthplace Baltimore

16 (a) Informant Wm A. Powell
(b) Address 3211 Tyndale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 1- (month) (day) (year)
(c) Cemetery or crematory Morelands Memo
Location Rural

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2005 Callaway St

19 (a) APR 30 1947 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/28 1947, at 8 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Last death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at ..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Earl L. Ringer M.D.
Medical Examiner.
Date signed 4/28/47

1198 513431

BALTIMORE CITY HEALTH DEPARTMENT X 937

CERTIFICATE OF DEATH

Registered No. G51198

Please write the causes of death clearly and legibly. Physicians: please write plainly. Improper or illegible reports will be returned for correction.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 225 Pinewood Road. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Mary Fisher.

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed.

6 (b) Name of husband or wife: Chas L. Fisher
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 9-18-67.

8. AGE: Years 79 | Months 78 | Days 7 | If less than one day ..... hr. ..... min. 11

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation .....
11. Industry or business At Home

FATHER
12. Name Albert Allen
13. Birthplace Md.

MOTHER
14. Maiden Name Charlotte ?
15. Birthplace Md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 2. (month) (day) (year)
(c) Cemetery or crematory Mountain Cem
Location Kingsville Md

18 (a) Funeral director Welsh Funeral Home
(b) Address 2008 Orleans St

(a) Date received by registrar APR 30 1947 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION A.

20. DATE OF DEATH April - 29 1947, at 5.43 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 12 1947, to April 29 1947, and that I last saw her alive on April 29 1947.

	Duration
Immediate cause of death: Uremia	7 days
Due to: Arteriosclerotic heart disease & hypertension	—
Due to:	
Other Conditions: Diverticulosis of colon with malena	—

(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature Marvin B. Day M. D.
Address Johns Hopkins Hosp. Date signed 29 Apr 47

5T199, 3939

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 5T199

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 629 E. Paca St (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Moses Roth

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-03-9964

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Dorothy Roth

6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) 10-12-1898

8. AGE: Years 48 | Months 6 - | Days 14 - | If less than one day .....hr. .....min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER 12. Name Richard Roth

13. Birthplace Va

MOTHER 14. Maiden Name Lucy Johnson

15. Birthplace Va

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof April 30 47 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn Cem

Location A.B. Co. Md

18 (a) Funeral director Isaiah L Brown Son

(b) Address 40 S W Monton St

APR 30 1947 (Date received by local registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 1947, at 7:30 a M

21. I certify that death occurred on the date above stated; that I attended deceased from April 21 1947, to April 26 1947, and that I last saw him alive on April 26 1947.

	Duration
Immediate cause of death: uremia	2 wks
Due to: nephrosclerotic renal disease.	8 mos
Due to:	
Other Conditions: Hypertension	? yrs

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... (Specify type of place) While at work?.....
(e) Means of injury.....

23. Signature Eugene Meyer III

Address Johns Hopkins Hosp. Date signed Apr 26 1947 M. D.

651200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 168

651200 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 6th
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3034 E. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES L Weaver

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Charlotte M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27, 1884

8. AGE: Years	Months	Days	If less than one day
62	11	1	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Charles Weaver
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name unknown
15. Birthplace

16 (a) Informant Charlotte M. Weaver
(b) Address 3034 East Baltimore Street

17 (a) Burial (b) Date thereof May 1 — 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director John G. Magan
(b) Address 3002 E. Balto. St.

19 APR 30 1947 Huntington Williams M.D.
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28 1947 at 3:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull &
Intracranial Hemorrhage.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death fill in the following:
(a) Date of injury 4-28-47 at 2:50 P.M.
(b) Where did injury occur? 215 N. Frederick St.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial Place While at work? yes
(d) Means of injury Blunt force

23. Signature Earl L. Kaylor M.D.
Medical Examiner.
Date signed 4-29-47

G51201

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
X 937

G51201
Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MARYLAND GENERAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 602 Murdock Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME VELMA M. HEIM

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): May 24 - 1902
8. AGE: Years 44 Months 11 Days 4 If less than one day hr. min.
9. Birthplace: Balto. Md. (town, county, state)
10. Usual Occupation: School Teacher
11. Industry or business

FATHER 12. Name: Warner D. Heim
13. Birthplace: Md.

MOTHER 14. Maiden Name: Mary E. Irland
15. Birthplace: Md.

16 (a) Informant: Warner D. Heim
(b) Address: 602 Murdock Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: May 1 - 47 (month) (day) (year)
(c) Cemetery or crematory: Lorraine Burial Park

18 (a) John A. McCrae
(b) Address: 300 E. Balto. St.

APR 30 1947 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/28 1947, at 3:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/28 1947 to 4/28 1947, and that I last saw her alive on 4/28 1947.

Immediate cause of death: PROBABLE CORONARY OCCLUSION OR CEREBRAL HEMORRHAGE — Duration: 4 HRS.
Due to: HYPERTENSIVE CARDIOVASCULAR DISEASE
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Charles W. Stewart, Jr. M. D.
Address: MD. GEN. HOSP. Date signed 4/29/47

51202

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 469

R 051202

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd. Calvert St.
(c) Hospital or institution:
Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 41
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Cecil
(c) City or town Port Deposit.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rural
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas W Bryson.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife Stella Bryson.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1892

8. AGE: Years 54 | Months 11 | Days 18 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name Robert Bryson
13. Birthplace Maryland

MOTHER
14. Maiden Name Virginia Bruce.
15. Birthplace Maryland.

16 (a) Informant Hospital Records Union Mem. Hosp.
(b) Address 33rd & Calvert St. Ba. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 2 1941 (month) (day) (year)
(c) Cemetery or crematory Asbury Cemetery
Location Port Deposit, Md R.D.

18 (a) Funeral director Lee A. Patterson & Son
(b) Address Owensville, Maryland

19 APR 30 1941 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1941, 5:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-19 1941 to 4-30 1941, and that I last saw h. alive on 4-30 1941.

Immediate cause of death: Generalized Carcinoma

Due to: Original Site

Due to: Carcinoma of pancreas

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Generalized Carcinomatosis

of autopsy:

Duration: Undet. / Undet.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norman R. Freeman M.D.

Address GMH Date signed 4-30-41

VS 150

X

203 BALTIMORE CITY HEALTH DEPARTMENT Registered No. C51203

CERTIFICATE OF DEATH 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 314 N. Carrollton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 314 N. Carrollton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward James

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-09-7945

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Agnes V.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1884

8. AGE: Years 62 | Months 11 | Days 12 | If less than one day: hr. min.

9. Birthplace Washington, D.C.
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name Beverly James
13. Birthplace Washington, D.C.

MOTHER
14. Maiden Name Mary Carter
15. Birthplace Fredericksburg, Va

16 (a) Informant Mrs. Agnes V. James
(b) Address 314 N. Carrollton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-30-1947 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George H. Hall
(b) Address 1631 Linfield Hill Rd

19 (a) Date received APR 29 1947 (b) Registrar Williams Mott

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-26- 1947, at 1:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1946 to April 26 1947 and that I last saw h[illegible] alive on April 24 1947.

Immediate cause of death
(a) Hypertensive Cardio Vascular Renal Dis.
Due to
(b)
Due to
(c)
Other Conditions Arteriosclerosis
(Include pregnancy within 3 months of death)

Duration
(a)
(b)
(c)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 600 N. Carrollton Ave Date signed 4/29/47

51204

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C51204

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 411 Cedarcroft Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 411 Cedarcroft Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY J. RAABE

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	216-03-6648

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Louise F. Raabe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/8/1872

8. AGE: Years	Months	Days	If less than one day
75	1	21	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Manager
11. Industry or business Wholesale Tobacco

FATHER
12. Name John F. Raabe
13. Birthplace Germany

MOTHER
14. Maiden Name Not Known
15. Birthplace Md.

16 (a) Informant Mrs. Lousie F. Raabe wife
(b) Address 411 Cedarcroft Rd.

17 (a) Burial (b) Date thereof 5/2/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral Com.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) APR 30 1947 (b) Huntington Williams M.D. Registrar
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 2 1945 to Apr 29 1947 and that I last saw h alive on Apr 29 1947.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Coronary Sclerosis	
Due to Generalized Arteriosclerosis	
Other Conditions Chr. Myocarditis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nathaniel M Beck M. D.
Address 1002 E. Fayette St Date signed Apr. 30, 1947

1205

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G51205 Registered No.

Type or write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 947 Homestead St.
(c) Hospital or institution: 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 947 Homestead St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY A. BROOKS

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Wm. A. Brooks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 18, 1867

8. AGE: Years	Months	Days	If less than one day
80	1	10	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Wm. Henry Lightner
13. Birthplace Baltimore

MOTHER
14. Maiden Name Margaret Pasco
15. Birthplace --

16 (a) Informant Mrs. G. M. Kolbe
(b) Address 947 Homestead St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/1/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

APR 30 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH April 28, 1947, at 1:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 28 1947, to April 28 1947, and that I last saw her alive on April 28 1947.

Immediate cause of death	Duration
Coronary Occlusion	1 day.
Due to	
Due to	
Other conditions Chronic bronchitis - 5 years	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury None

23. Signature R. L. Gordy M.D.
Address 5106 Harford Rd. Date signed 4/29/47

X

51206

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

Registered No. C51206

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2539 Penna. Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) P
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2539 Penna. Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BUSTER GILYARD

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 251-01-6203

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Separated

6 (b) Name of husband or wife: Nancy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/30/1912

8. AGE: Years	Months	Days	If less than one day
35	0	29	hr. min.

9. Birthplace Winnsboro, S.C.
(Town, county, and state)
10. Usual Occupation Bathtub maker
11. Industry or business Carpenter

FATHER
12. Name Wm. Gilyard
13. Birthplace S.C.

MOTHER
14. Maiden Name Luvenia Howard
15. Birthplace Winnsboro, S.C.

16 (a) Informant Luvenia Gilyard (MOther)
(b) Address 2539 Penna. Ave

17 (a) Burial (b) Date thereof 5/4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Lukes
Location Winnsboro, S.C.

18 (a) Funeral director Charles G. Cooper
(b) Address 519-512 N. Carrollton Ave

APR 30 1947 Huntington Williams M.D.
(Registrar)

VS 180

MEDICAL CERTIFICATION

P

20. DATE OF DEATH: 4/28/47 19 at 3:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/23 1947 to 4/28 1947 and that I last saw h[illegible] alive on 4/28 1947

Immediate cause of death	Duration
Pulmonary TB	2 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 2539 Penna Ave Date signed 4/29/47

51207

TN. 109753

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V.13B

G51207 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: 4940 Eastern Ave

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days): 17 days

(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:

(a) State: Maryland (b) County:

(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No.: 1213 E. Franklin St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country:

3 (a) FULL NAME: Thomas Coleman

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: Male

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 21st. 1927

8. AGE: Years: 20 Months: 3 Days: 5 If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Huckster

11. Industry or business: Self

FATHER

12. Name: Thomas Coleman (D

13. Birthplace: Maryland

MOTHER

14. Maiden Name: Georganna Shorter

15. Birthplace: Maryland

16 (a) Informant: Baltimore City Hospitals

(b) Address: 4940 Eastern Ave (Records)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/30/47 (month) (day) (year)

(c) Cemetery or crematory: Mt. Zion

Location: Balto. County, Md.

18 (a) Funeral director: Charles G. Cooper

(b) Address: 510-12 N. Carrollton Ave.

19 (a) APR 30 1947 (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 26th 1947 19 , at 12.50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 9th 19 47 to Apr. 26 19 47, and that I last saw h im alive on April 26th 1947

Immediate cause of death: Pulmonary Tbc.

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: —

of autopsy: As above

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide:

(b) Date of occurrence: at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury:

23. Signature: H.H. Faulkner M. D.

Address: Balto City Hosp. Date signed: 4-26-47

VS 150

X

5 1208

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G5 1208
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution:
South Balto general hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 500 Old Annapolis Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Riley

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
No	173-10-7197	Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1894

8. AGE: Years	Months	Days	If less than one day
53	2		hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Riley
13. Birthplace Maryland

MOTHER
14. Maiden Name Ida Barbara Stumpf
15. Birthplace Maryland

16 (a) Informant Anna K Clopper
(b) Address 500 Old annapolis Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/2/47 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore Md
18 (a) Funeral director Wilson Corby Inc
(b) Address 1219 Park Ave
APR 30 1947 (Registrar's signature) for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1947 at 3 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 27 1947 to April 29 1947 and that I last saw h[illegible] alive on April 29 1947

Immediate cause of death: Acute Cardiac Failure — Duration

Due to: Coronary occlusion

Due to:

Other Conditions: Bilateral Lobar pneumonia.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Rocco L. Laporta M. D.
Address S. B. G. Hosp. Date signed 4/29/47

VS 150

94a

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51209

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1940

G51209 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dix.
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 4913 Towne St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country Towne

3 (a) FULL NAME Louise Reisland (Reinland)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 67 | Months | Days | If less than one day ....hr. ....min.

9. Birthplace Balto, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ? Nicol
13. Birthplace Unk

MOTHER
14. Maiden Name Unk
15. Birthplace "

16 (a) Informant Sadie Taylor
(b) Address 712 S. Oldham St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-1-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location O'Donnell St.

18 (a) Funeral director John F. Connally
(b) Address 918 Eastern Ave, Balto 24, Md.

19 (a) Apr 30 1947 (Date rec'd by Local Registrar) (b) Huntington Williams, M.D. (Local Registrar)

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/28 1947, at 1:35 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ....at .... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D. (Medical Examiner.)
Date signed 4/29/47

51210

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G51210 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 408 Laurens Av.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 da
(e) Length of stay in Baltimore (yrs., mos., or days) 71 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 408 Laurens Av
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Teresa Redout

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widowed

6 (b) Name of husband or wife Katie Redout
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 1, 1876

8. AGE: Years	Months	Days	If less than one day
71		28	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER 12. Name	Unknown
FATHER 13. Birthplace	Unknown
MOTHER 14. Maiden Name	Unknown
MOTHER 15. Birthplace	Unknown

16 (a) Informant Leonard Redout
(b) Address 408 Laurens Av

17 (a) Burial (b) Date thereof 5/3/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Zion
Location Md

18 (a) Funeral director Geo. B. Kelson
(b) Address 1343 Pennsylvania Ave.

APR 30 1947 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 29 1947, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 15 1947 to Apr 29 1947 and that I last saw him alive on Apr 28 1947.

Immediate cause of death	Duration
Cardio Vascular Disease	?
Due to Broken Compression	2 months
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Williams Jr M.D.
Address 1928 Penna Ave Date signed 4/30/47

VS 150

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51211

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 192c

Registered No. G51211

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 Caroline St.
(c) Hospital or institution: St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 305 Foleroft St.
(If rural give location)
(e) Citizen of foreign country? [illegible] (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Julianna Lydelska

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 8 - 1894

8. AGE: Years 52 | Months 5 | Days 21 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Jacob Dawnya
13. Birthplace Poland

MOTHER
14. Maiden Name Maryanna Kacznarek
15. Birthplace Poland

16 (a) Informant John Lydelski
(b) Address 305 Foleroft St.

17 (a) Burial (b) Date thereof 5-3-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore Md.

18 (a) Funeral director George A Weber
(b) Address 705 S. Ann st.
(c) Date received by registrar APR 30 1947 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29th 1947, at 6.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 18 1947, to April 29 1947, and that I last saw her alive on April 29 1947:

Immediate cause of death: Cardio-Respiratory failure. — Duration

Due to: Cardiac decompensation

Due to: Rheumatic valvular disease.

Other Conditions: Anemia, secondary, etiology undetermined.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard A. Young M. D.
Address St. Joseph's Hosp. Date signed 4/29/47

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51212

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G51212
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 dys
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mass. (b) County
(c) City or town Newtonville,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 156 Highland ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Heidi Booth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, ~~married, widowed, or divorced.~~

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1-2-44

8. AGE: Years 3 | Months —3 | Days —27 | If less than one day — hr. — min.

9. Birthplace Mass.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Booth
13. Birthplace Mass.

MOTHER 14. Maiden Name Jeanne ?
15. Birthplace Mass.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/30/47 (month) (day) (year)

(c) Cemetery or crematory
Location Newton, Mass

18 (a) Funeral director Fabian C. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) (b) Registrar

APR 30 1947
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-29-1947, at 805 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-23-1947, to 4-29-1947, and that I last saw her alive on 4-29-1947.

Immediate cause of death Atelectasis left lung, Pleural effusion, right

Due to

Due to

Other Conditions Congenital heart disease. Tetralogy of Fallot
(Include pregnancy within 3 months of death)

Date of operation 4-25-47

Major findings of operation: Pulmonary artery stenosis

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature George L Palmer M. D.
Address Harriet Lane Home Date signed 4-29-47

Please write the causes of death clearly and legibly. Physicians: please write

C51213

AB-10924 B C# 4-50309

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

C51213 / 12B

Registered No.

Please write the causes of death clearly and legibly. Physicians: Please write legibly. Typewriter preferred. Use no abbreviations.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo-12days
(e) Length of stay in Baltimore (yrs., mos., or days) 1mo-12days

2. USUAL RESIDENCE OF DECEASED: Howard Co.
(a) State Md. (b) County Baltimore
(c) City or town Rural-West Friendship
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Arthur Harless

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 25- 1946

8. AGE: Years	Months	Days	If less than one day
	10	4	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Perry Harless
13. Birthplace Tenn.

MOTHER
14. Maiden Name Murial Campbell
15. Birthplace Tenn.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-3-47 (month) (day) (year)
(c) Cemetery or crematory Sugarville
Location Sugarville Carroll Co Md

18 (a) Funeral director H C Ney suburban
(b) Address Ellicott City Md

(b) Huntington Williams M.D. Registrar

APR 30 1947

VS 150

MEDICAL CERTIFICATION pm.

20. DATE OF DEATH April 29 1947 at 12.25M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-17 1947, to 4-29 1947, and that I last saw him alive on 4-29 1947.

Immediate cause of death: Tuberculous meningitis — Duration 2 mos.
Due to
Due to
Other Conditions: miliary pulmonary TBc
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wilson E. Hughes M. D.
Address Balto City Hosp Date signed Apr. 30 47

X

G51214

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G51214 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 951 Forest St
(c) Hospital or institution:
10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 957 Forest St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Col

6 (a) Single, married, widowed, or divorced: Sep.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years 50 | Months | Days | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Ned Smith

13. Birthplace Va

MOTHER 14. Maiden Name Minnie Goring

15. Birthplace Va.

16 (a) Informant Algie May Moore

(b) Address 1424 E. Madison St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 1-1947 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem

Location Brooklyn Md

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Bentley ave

19 (a) (Date rec'd by registrar) (b) Registrar

APR 30 1947 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-28 1947, at 3.50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/20 1947, to 4/27 1947 and that I last saw her alive on 4/27 1947.

Immediate cause of death	Duration
Acute Myocardial infarction	
Due to Ch arteriosclerosis	
Due to Acute Uremia	
Other Conditions Ch nephritis	
Ch Hypertention	

(Includg pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. L. Hornstein M. D.

Address 733 Augusta St Date signed 4/29/47

94a

Write the causes of death clearly and legibly. Physicians: please write in ink, avoid abbreviations, and supply all items.

G51215
35-7805

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G51215
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write as legibly as typewriting. Important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 924 Watson, St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Faris Butler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	black	married

6 (b) Name of husband or wife Minnie Butler
6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) 5-1-09

8. AGE: Years	Months	Days	If less than one day
37	11	26	hr. min.

9. Birthplace S.C.
(Town, county, and state)
10. Usual Occupation Rigger
11. Industry or business

FATHER
12. Name Oscar Rhoten
13. Birthplace S.C.

MOTHER
14. Maiden Name Della Butler
15. Birthplace S.C.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof April 30, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location Baltimore, Md
18 (a) Funeral director Elwood E. Wilson
(b) Address 1008 Bentley ave
19 (a) (b)
(Date received by Registrar) (Registrar)

APR 30 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 - 1947 at 11-15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-22 - 1947 to 4-27-1947, and that I last saw him alive on 4-27-1947.

	Duration
Immediate cause of death Uremia	2 yrs
Due to Cause unknown	
Due to	
Other Conditions Chronic myocarditis	2 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address JHH Date signed 4/28/47

X

JL - 1101 G51216

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 83a

Registered No. G51216

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 21

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1030 S. Eutaw St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Larry Reid

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 27, 1938

8. AGE: Years: 8 | Months: 8 | Days: 1 | If less than one day: hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation School

11. Industry or business

FATHER
12. Name Jesse Reid
13. Birthplace Ala.

MOTHER
14. Maiden Name Gladys Harrible
15. Birthplace Pa.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 2, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cem.
Location Brooklyn Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1020 Brantley ave

MAY 20 1947 (Local registrar) (b) Huntingtown Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28 1947, at 8.25A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 23 1947, to April 28 1947, and that I last saw h. alive on April 28 1947.

Immediate cause of death: Sub-arachnoid Hemorrhage — Duration: 1 day

Due to

Due to

Other Conditions: Sickle Cell Anemia — 4 yrs.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Sub arachnoid Hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Julian V. Duffin M. D.
Address Bal. City Hosp. Date signed Apr. 28 1947

VS 150

Please write the causes of death clearly and legibly. Physicians: please write age if expectancy important.

G51217

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1947

G51217 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1310 Northwern Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1310 Northwern Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Johanna (Josephine) O'Grady

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Almira L Cash
(b) Address 1310 Northwern Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 1-47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd

18 (a) Funeral director Joseph Kaltenbach
(b) Address 602 Washington Blvd

19 (a) APR 30 1947 (Date rec'd by registrar) (b) Washington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 April 1947, at 2:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 1947 to 28 April 1947, and that I last saw her alive on 27 April 1947

Immediate cause of death: Cerebral Hemorrhage — Duration: 1 mo.

Due to: Arteriosclerosis Hypertensive Cardio-Vascular — Duration: 5 yrs.

Due to: Nephritis

Other Conditions: Thrombophlebitis left leg.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Wm. H. Kammer, Jr. M. D.
Address 501 Sheridan Ave. Date signed 29 April 1947

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51218

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G51218
Registered No.

Please write the causes of death clearly and legibly. Physicians; please write as legibly as possible. Your signature is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bruce & Lombard St.
(c) Hospital or institution:
University Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) Unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 715 Chilton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sophia Meyer (SOPHIA MEYER)

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Frederick Meyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 13, 1858

8. AGE: Years 88 | Months 4 | Days 17 | If less than one day ____ hr. ____ min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation H.W.

11. Industry or business

FATHER 12. Name Christian Grundgreper
13. Birthplace Germany

MOTHER 14. Maiden Name Sophia Eberwein
15. Birthplace Germany

16 (a) Informant Mrs. Charles Schwartz
(b) Address 1715 Chilton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/3/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) Date received by registrar APR 30 1947 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-30 1947, at 12:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-26 1947 to 4-30 1947, and that I last saw h Cr alive on 4-30 1947.

	Duration
Immediate cause of death Bronchial Pneumonia	
Due to Renal shutdown	
Due to MILD CARDIAC Decompensation	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] Bevorkman M. D.
Address University Dept. Date signed 4-30-47

G51219

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G51219
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write as completely as necessary. Time, date, and correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Gram & Lombard
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) 11

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Annapolis
(If outside city or town limits, write RURAL and give town)
(d) Street No. 130 Market St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Kramer

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 12 - 1887

8. AGE: Years	Months	Days	If less than one day
59	5	17	hr. min.

9. Birthplace Maryland Annapolis
(Town, county, and state)

10. Usual Occupation Engineer

11. Industry or business

FATHER
12. Name Anton J Kramer
13. Birthplace N.J. New Jersey

MOTHER
14. Maiden Name Catherine Elizabeth
15. Birthplace Germany Annapolis, Md

16 (a) Informant Mrs. Frederick Kramer
(b) Address Annapolis Md

17 (a) Burial (b) Date thereof May 2 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Mary's
Location Annapolis Md

18 (a) Funeral director C Lithgow Inc
(b) Address Annapolis Md

19 (a) (b)
(Date registered) (Registrar)

APR 30 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/29 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/18 1947 to 4/29 1947, and that I last saw H.M. alive on 4/29 1947.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George F Nassenburg Jr M. D.
Address University Hosp Date signed 4/22/47

X

G51220

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G51220 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1628 Carswell St.
(c) Hospital or institution: 91
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1628 Carswell St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vincent Sica

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: 215-01-0532

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rosaria
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 20 1884

8. AGE: Years	Months	Days	If less than one day
63	3	8	hr. min.

9. Birthplace: Italy (Town, county, and state)
10. Usual Occupation: Tailor
11. Industry or business: Tailor Shop

FATHER
12. Name: Luigi Sica
13. Birthplace: Italy

MOTHER
14. Maiden Name: Josephine ?
15. Birthplace: Italy

16 (a) Informant: Louis Sica (Son)
(b) Address: 1628 Carswell St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: May 1st/47 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Rd. Baltimore Md.

18 (a) Funeral director: Frank Dellacase
(b) Address: 52 N. Morley St.

APR 30 1947 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28 1947 at 4:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 26 1947 to April 28 1947.
and that I last saw him alive on April 28 1947.

Immediate cause of death: Myocardial failure — Duration: 2 Months
Due to: Hypertensive Cardio-Vascular disease — 15 yrs
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:
23. Signature: Howard L. Wardley M.D.
Address: 2900 Olympia Date signed: April 29, 1947

Huntington Williams, M.D. Registrar

G51221

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1579

G51221

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the age at which each cause began to operate. It is especially important. Typewriting supplies the

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood & Greene Sts.

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12.

(e) Length of stay in Baltimore (yrs., mos., or days) 1 mo.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Howard

(c) City or town Ellicott City

(If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Herbert Johnson Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20 1947

8. AGE: Years	Months	Days	If less than one day
	1	19	hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Herbert Johnson

13. Birthplace Md

MOTHER

14. Maiden Name Lorraine Mayne

15. Birthplace Md

16 (a) Informant Herbert Johnson

(b) Address Ellicott City Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-2-47 (month) (day) (year)

(c) Cemetery or crematory St Johns

Location Ellicott City

18 (a) Funeral director E. C. Figgs Bothers

(b) Address Ellicott City Md

19 (a) APR 30 1947 (Date received by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29, 1947 at 10:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 28, 1947 to April 29, 1947 and that I last saw him alive on Apr. 29, 1947.

Immediate cause of death Anoxia	Duration
Due to Atelectasis	
Due to Pyloric Stenosis	
Other Conditions Possible Intra-cranial Hemorrhage	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy Atelectasis, Pyloric Stenosis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide None

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [signature]

M. D.

Address University Hospital Date signed 4-30-47

X

G51222

CMK-109602

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G51222

Please write the causes of death clearly and legibly. Physicians: please write correct age if especially important. Any erasure, alteration or illegible entry suppresses.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 49- 3- 6-

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1405 Kuper Place (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME: Ella Lutts

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Edwin C. Lutts
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 23-1898

8. AGE: Years	Months	Days	If less than one day
49	3	6	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Henry D. Sarbacker
13. Birthplace Maryland

MOTHER
14. Maiden Name Ella ? Brundige
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-2-47 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Baltimore, Md.

18 (a) Funeral director George L. Schwab
(b) Address 2104 Frederick Ave.

19 (a) MAY 1 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH April 29 19 47 at 7:28 M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 2 1947, to Apr. 29 19 47, and that I last saw h. or alive on Apr. 29 19 47.

Immediate cause of death	Duration
Cardiac failure	
Due to ASCVD	
Due to	
Other Conditions Basilla carcinoma of uterus	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Doyle Waldron M. D.
Address B. C. H. Date signed 4-30-47

VS 150

G51223 MINNER

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G51223

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St. & Linden Ave.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 14
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1615 Johns St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George T. Minner

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-16-3781

4. Sex M | 5. Color or race W | 6 (a) Single, ~~married, widowed, or divorced~~ Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years 57 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Guard

11. Industry or business Printing, Book Trade

FATHER 12. Name Geo. H. Minner

13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Susie McCarthy

15. Birthplace Balto. Md.

16 (a) Informant Charles V. Minner

(b) Address 2132 W. Lexington St

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 5/3/47 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Cathedral

Location Balto. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 127 St. Paul St.

MAY 1 - 1947 (Date rec'd by Registrar) (b) Signature for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 Apr 1947, at 9:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 29 Apr 1947 to 30 Apr 1947 and that I last saw him alive on Apr. 30 1947.

	Duration
Immediate cause of death: Cerebral Hemorrhage	16 hrs
Due to: Hypertension, Cardio-Vascular Disease	2
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. Allan Spiel, M.D.

Address Md. Gen. Hosp. Date signed 2 May 47

VS 150

correct age in especially important. Physicians: please write the causes of death clearly and legibly.

MINNIE KLEIN

G51224

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G5L224

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Maryland General Hosp. 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 10
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5313 St. Georges Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Minnie Klein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr.) 26 March 1867

8. AGE: Years	Months	Days	If less than one day
80	1	2	..... hr. ..... min.

9. Birthplace Germany.
(Town, county, and state)

10. Usual Occupation

11. Industry or business —

FATHER
12. Name John A. Kellermann
13. Birthplace Germany.

MOTHER
14. Maiden Name Sanders
15. Birthplace Germany.

16 (a) Informant Mrs Jackel
(b) Address 531 B St Georges Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 1, 47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director L. Hemmann & Son
(b) Address 6067 Harford Rd

19 (d) MAY 1 - 1947 Huntington Williams, M.D.
Registered by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 April 1947, at 8:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5 April 1947 to 28 April 1947 and that I last saw her alive on 28 April 1947.

Immediate cause of death: Cardiac decompensation — Duration

Due to

Due to

Other Conditions Fracture of rt. hip.
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 27/10
(a) Accident, ~~suicide, or homicide~~
(b) Date of occurrence 5 April 1947 at 8 P.M.
(c) Where did injury occur? Balto (City or town) (County) Md. (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? no
(e) Means of injury Fell at home (alleged)

23. Signature M.T. McBoyer M.D.
Address Md. Gen. Hosp. Date signed 28 April 1947

Earl L. Royer M.D. X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G51225

BALTIMORE CITY HEALTH DEPARTMENT X ✓

CERTIFICATE OF DEATH 94a

Registered No. G51225

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Stafford Hotel
(b) Street address Charles & Madison Sts.
(c) Hospital or institution:
none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 weeks

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Bradford
(If outside city or town limits, write RURAL and give town)
(d) Street No. 119 Jackson Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph H. Bovaird

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Emma Griffith
6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) December 3, 1869

8. AGE: Years	Months	Days	If less than one day
77	4	28	..... hr. ..... min.

9. Birthplace Shamburg, Pa.
(Town, county, and state)
10. Usual Occupation Oil Well supplies - retired
11. Industry or business

FATHER
12. Name David Bovaird
13. Birthplace Scotland

MOTHER
14. Maiden Name Mary McLennahan
15. Birthplace North Ireland

16 (a) Informant Mrs. Emma G. Bovaird
(b) Address 119 Jackson Ave., Bradford, Pa.

17 (a) Burial (b) Date thereof May 5, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~crematory~~ Willowdale
Location Bradford, Pa.

18 (a) Funeral director John O. Mitchell Est. Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) MAY 1 1947 (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1947 at 2.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 1947 to May 1 1947, and that I last saw him alive on May 1 1947.

Immediate cause of death	Duration
Coronary Heart Disease	
Due to arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas P. Sprunt M. D.
Address 1035 N. Calvert St. Date signed

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

VS 150

X

G51226

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G51226

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 W. Henrietta Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 212 W. Henrietta St. 2
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SOPHRONIA WOODHOUSE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1892

8. AGE: Years	Months	Days	If less than one day
55	1		hr. min.

9. Birthplace Norfolk, Virginia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Wrighty Bray
13. Birthplace Va.

MOTHER
14. Maiden Name Hannah Ford
15. Birthplace Va.

16 (a) Informant Estelle Dudley
(b) Address 212 W. Henrietta St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-1-1947 (month) (day) (year)

(c) Cemetery or crematory
Location Berkely, Virginia

18 (a) Funeral director Mrs. Frances A. Remsley
(b) Address 578 W. Biddle St.

19 (a) MAY 1 - 1947 (b) [illegible]
(Date received by Registrar) [illegible]

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH April 27 19 47 at 5:35 M

21. I certify that death occurred on the date above stated, that I attended deceased from April 23 19 47 to April 27 19 47 and that I last saw h[illegible] alive on April 27 19 47.

Immediate cause of death: Myocardial Infarct — Duration 2 da

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]
Address [illegible] M.D. Date signed 5/2/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C51227

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. C51227

Please write the causes of death clearly and legibly. Physicians: please write in ink. Do not use abbreviations. Please answer all questions.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1413 Kuper Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 - 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1413 Kuper Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Harnett

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Patrick

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1867

8. AGE: Years 84 85 | Months 5 | Days | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Dennis Buckley
13. Birthplace Ireland

MOTHER 14. Maiden Name Johanna Connor
15. Birthplace Ireland

16 (a) Informant Margaret Cryan
(b) Address 1413 Kuper Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 2-1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto Md

18 (a) Funeral director Patt & B. M. Walter
(b) Address Patterson Park Ave

19 MAY 1 - 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Address

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30th 1947, at 7:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 11 1947 to April 30 1947 and that I last saw her alive on April 30 1947.

Immediate cause of death	Duration
Myocardial Failure	
Due to Adeno-carcinoma of Breast	1 year
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John F. Callahan M. D.
Address 24 N. Fulton Ave Date signed 4/30/47

VS 150

X

G51228

AB-110209

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G51228

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4days
(e) Length of stay in Baltimore (yrs., mos., or days) 44yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1512 McElderry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fred. [illegible] Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Ella
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 20- 1895

8. AGE: Years	Months	Days	If less than one day
51	11	10	hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation Machine Operator
11. Industry or business

FATHER
12. Name James Robert Brown(D
13. Birthplace Virginia

MOTHER
14. Maiden Name Adelina Johnson
15. Birthplace Virginia

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 3, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn Md
18 (a) Funeral director Elroy S. Wilson
(b) Address 1000 Bushby St Williamsport

19 (a) Filed by (b) Registrar

MAY 1 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1947, at 5.15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-26- 1947, to 4-30 1947, and that I last saw h in alive on 4-30 1947.

Immediate cause of death	Duration
Meningitis	
Due to Miliary Tbc.	
Due to	
Other Conditions Tbc. Epididymitis. N. III Paralysis. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert A. Faeber M. D.
Address Balto City Hosps Date signed 4-30-47

correct age as especially important. Physicians: please write the causes of death clearly and legibly.

G51229

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

143 B

Registered No. G51229

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1610 Riggs ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1610 Riggs Avenue (If no street give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Brafton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Raphael Brafton

6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) 1919

8. AGE: Years 28 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Richmond Va (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Frank Thomas
13. Birthplace unknown

MOTHER
14. Maiden Name Neal Hopson
15. Birthplace Richmond Va.

16 (a) Informant Raphael Brafton
(b) Address 1631 N. Mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/3/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location West Port Balto Md

18 (a) Funeral director Metropolitan Funeral Home
(b) Address 927 N. Mount St. Inc

19 MAY 1 - 1947 Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1947, at 1:50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive cardiovascular disease

Due to

Other Conditions Pregnancy - approx 4½ mos. Status interus Hemorrhage
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl Royer M.D.
Medical Examiner.
Date signed

VS 181

937

G51230

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

98

G51230 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1414 Ward St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1414 Wand St. Balto Md. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances R. Anderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Colored

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Patrick Anderson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 70 yr | Months — | Days — | If less than one day hr. min.

9. Birthplace Howard Co. Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

MOTHER / FATHER

12. Name John Powell

13. Birthplace Howard Co. Md.

14. Maiden Name Frances Collins

15. Birthplace Howard Co. Md

16 (a) Informant Martha A. Roberts

(b) Address 1414 Ward St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/2/47 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location West Port. Balto. Md.

18 (a) Funeral director Metropolitan Funeral Home

(b) Address 2219 W. Mount St. Balto

19 (a) MAY 1 1947 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1947, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 22 1947, to April 29 1947, and that I last saw her alive on April 29 1947.

Immediate cause of death Uremia — Duration 2 days

Due to Renal Nephritis — Duration ?

Due to Gangrene of Foot — Duration ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury —

23. Signature Douglas Sheppard M. D.

Address 404 N. Bultimore Date signed 4/29/47

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51231

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

Registered No. G51231

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 109 dys.
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) 2
(d) Street No. 1723 Division St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe	N	widow

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/27/93

8. AGE: Years	Months	Days	If less than one day
54	-	1	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant John T. Woodland
(b) Address 524 Wilson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 1, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Geo. W. Walland
(b) Address 1631 Druid Hill Ave.

19 MAY 1 - 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/28 1947 at 6 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/9 1947 to 4/28 1947 and that I last saw h[illegible] alive on 4/28 1947.

Immediate cause of death Hypertension Cardio-Vas Ren Renal Disease

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 4-30-47

correct age is especially important. Physicians: please write the cause of death clearly and legibly. The name of informant should be carefully supplied. The

VS 150

C51232

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Register No. C51232

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Use only black ink. Please do not write above or below the lines. Be sure that every item is correctly supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2417 Madison Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sallie Ann Mercer

3 (b) If veteran, name war

3 (c) Social Security Account No. NONE

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 2, 1878

8. AGE: Years 69 | Months 3 4 | Days 27 | If less than one day hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Joseph Lindsay
13. Birthplace Rocky Mount, N.C.

MOTHER
14. Maiden Name Mary Thorpe
15. Birthplace Rocky Mount, N.C.

16 (a) Informant William T. Mercer
(b) Address 2417 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 2, 1947 (month) (day) (year)
(c) Cemetery or crematory ARBUTUS Memorial Pk
Location Baltimore Co. Md.

18 (a) Funeral director Wm. George A. Hoeland
(b) Address 1631 Druid Hill Ave.

MAY 1 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1947, at 8 30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 22 1947 to April 29 1947, and that I last saw her alive on April 29 1947.

Immediate cause of death: Uremia — Duration

Due to: Hypertensive Cardio-Vascular Renal Disease

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. B. Huggins, M. D.
Address 2423 Madison Date signed 5-2-47

X

G51233

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G51233

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4613 ParkHeights Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-2
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 812 W North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Simon Lease

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-6091

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ida

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 65 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER 12. Name Hyman Louis Lease
13. Birthplace Russia

MOTHER 14. Maiden Name Sarah Bartel
15. Birthplace Russia

16 (a) Informant Miss Sadie Lease
(b) Address 812 W North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 1, 1947 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 MAY 1 - 1947 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION 12:00

20. DATE OF DEATH April 30 1947 12 Noon M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1941 to Apr 30 1947, and that I last saw h.im alive on Apr 29 1947.

Immediate cause of death Cardiac failure — Duration

Due to Myocardial Hypertrophy & Dilatation

Due to Arteriosclerosis

Other Conditions Cerebral Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. Lurkey M. D.
Address 2116 W. Pratt St. Date signed 4/30/47

V S 150

X

Please write the causes of death clearly and legibly. Physicians: please write as especially important. Please write the causes of death clearly and legibly.

G51234

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G51234

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2228 Ruskin ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2228 Ruskin Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Meyer Millman

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Dora
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1860

8. AGE: Years	Months	Days	If less than one day
87			hr. min.

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name David Milliman
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant David A. Millman
(b) Address 2228 Ruskin Ave.

17 (a) Burial (b) Date thereof May 2/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Cemetery
Location 3600 E. Balto. St.

18 (a) Funeral director SOL LEVINSON & BROS.
(b) Address 1124-26 W. North Ave.

19 MAY 1 - 1947 Huntington Williams, Registrar
(Date rec'd by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1947, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 12 1946 to April 30 1947, and that I last saw h[illegible] alive on April 30 1947.

Immediate cause of death	Duration
UREMIA	
Due to Arteriosclerotic Generalized Sclerosis	Pakaia
Due to Congestive Heart Failure	
Other Conditions Senility	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Willard Oppenheimer M.D.
Address 2511 Reisterstown Rd Date signed 4/1/47

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51235

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G51235

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2416 Brambleton Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 + 15

(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2416 Brambleton Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH KIMMEL

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Rosa Kimmel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 3, 1870

8. AGE: Years	Months	Days	If less than one day
76	6	26	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Musician
11. Industry or business Self

FATHER
12. Name Simon Kimmel
13. Birthplace Germany

MOTHER
14. Maiden Name Theresa Theisz
15. Birthplace Germany

16 (a) Informant Mrs. Urban Link
(b) Address 2416 Brambleton Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/2/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 MAY 1 - 1947 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION A

20. DATE OF DEATH Apr. 29, 1947, at 10:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1946 to Apr 29 1947, and that I last saw him alive on Apr 29 1947.

Immediate cause of death	Duration
Coronary thrombosis	12 hrs
Due to arteriosclerosis	7 yrs
Due to Untreated Nephritis	7 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sherman Marks M. D.
Address 2601 Mountlawn Av. Date signed 4/30/47

VS 150

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

G51236

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

✓ G51236 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison St.
(c) Hospital or institution:
Maryland General Hosp. 156
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1608 Poplar Grove St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mildred S. Edwards

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife: Amos G. Edwards
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 12, 1901

8. AGE: Years	Months	Days	If less than one day
46	1	17	hr. min.

9. Birthplace Centerville, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ? Shaw
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mr. Amos G. Edwards
(b) Address 1608 Poplar Grove St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 5/1/47 (month) (day) (year)
(c) Cemetery or crematory
Location Chester, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAY 1 - 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/29 1947 at 5:07 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/19 1947 to 4/29 1947 and that I last saw her alive on 4/29 1947

Immediate cause of death	Duration
General circulatory Collapse	
Due to metastatic carcinoma Intestinal obstruction	
Due to	over
Other Conditions none	

(Include pregnancy within 3 months of death)
Date of operation 4/22/47
Major findings of operation: intestinal obstruction
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John E Miller M.D.
Address Maryland Gen'l Hosp. Date signed 4/30/47

VS 150

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51237

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5 0 ✓

Registered No. G51237

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1424 RIVERSIDE AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) ~~Street~~ 3 Street No. 1424 RIVERSIDE AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA GERTRUDE SNYDER

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	MARRIED

6 (b) Name of husband or wife JOHN W. SNYDER
6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) OCT 10, 1878

8. AGE: Years	Months	Days	If less than one day
68	6	19	hr. min.

9. Birthplace TEXAS, MARYLAND (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business

FATHER
12. Name JOHN HOUCK
13. Birthplace YORK, PA

MOTHER
14. Maiden Name MARY DUGAN
15. Birthplace TEXAS, MD.

16 (a) Informant JOHN W. SNYDER
(b) Address 1424 RIVERSIDE AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 5 2 47 (month) (day) (year)
(c) Cemetery or crematory LOUDON PK.
Location FREDERICK RD.

18 (a) Funeral director JOHN F. DENNY, INC.
(b) Address 715 LIGHT ST.

19 (Date received by registrar) MAY 1 – 1947 Huntingtown Williams, M... Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 29, 1947, at 6 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/23 1946 to 4/29 1947 and that I last saw h.. alive on 4/28 1947

Immediate cause of death: General Cancerous

Due to malignant tumor of left breast

Due to

Other Conditions Acute cardiac failure (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
?
10 yrs.
7 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature S. H. Hartman M. D.
Address 436 E Fortam Date signed 4/30/47

X

Green ✓

G51238

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 17a

G51238 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important. The information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 906 - Wheatcroft St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-2
(e) Length of stay in Baltimore (yrs., mos., or days) 49

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 906 Wheatcroft (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Walter Green

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-5392

4. Sex Male | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mildred Green

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years 49 | Months | Days | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name Charles Green
13. Birthplace Md. County

MOTHER
14. Maiden Name Cotter
15. Birthplace Md.

16 (a) Informant Mildred Green
(b) Address 906 Wheatcroft St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/3/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location L. A. Co. Md.

18 (a) Funeral director Metropolitan Funeral Home
(b) Address 927 N. Mount St Dec

MAY 1 1947 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/30/47 19 , at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1 19 47 to 4/30 19 47.
and that I last saw h alive on 4/28 1947.

Immediate cause of death	Duration
(a) Carcinoma of Rectum	1 Year
Due to (b) Metastasis	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M.D.
Address 600 Cathedral signed 5/1/47

VS 150

G51239

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G51239

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1732 E. Fayette St
(c) Hospital or institution: 6-6

(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 Yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1732 E Fayette St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Geeser

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Eva

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
71			hr. min.

9. Birthplace Russia (City, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER 12. Name Arnold

13. Birthplace Russia

MOTHER 14. Maiden Name Jessie

15. Birthplace Russia

16 (a) Informant Eva Geeser

(b) Address 1732 E. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-1-47 (month) (day) (year)

(c) Cemetery or crematory Hebrew Mt Carmel

Location

18 (a) Funeral director Jack Lewis Inc

(b) Address 1409 E Balto St

19 (a) MAY 1 - 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-1-1947, at 3A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 15 1946, to April 30 1946 and that I last saw him alive on April 30-46

Immediate cause of death: Acute Cardiac dilatation 1hr — Duration

Due to: Chron Myocarditis 2yrs

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M D Baylin

Address 7040 Eldean Date signed 5/1/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G51240

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8 3a

Registered No. G51240

Please write the causes of death clearly and legibly. Physicians: please write as accurately and completely as necessary supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2411 Eutaw Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Siegel

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	married

6 (b) Name of husband or wife Sadie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) -1890

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation merchant

11. Industry or business

FATHER
12. Name Jacob
13. Birthplace Austria

MOTHER
14. Maiden Name Fanani
15. Birthplace Austria

16 (a) Informant Wife
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-2-47 (month) (day) (year)
(c) Cemetery or crematory Ohab Shalom
Location O'Donnell St

18 (a) Funeral director Jack Levin Inc
(b) Address 2400 Eutaw Place

19 (Signature of local registrar) MAY 1 - 1947 Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1947, at 8P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1943 to April 30 1947, and that I last saw him alive on April 29 1947.

Immediate cause of death	Duration
Monoma cerebral hemorrhage	3 weeks
Due to Hypertension	12 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel L Libow M. D.
Address 1720 Eutaw Pl Date signed 4/30/47

G51211

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48B

Registered No. G51211

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline Street
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2116 Ashland Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Kozlovsky, Elizabeth A.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: August Frank
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 4/17/86

8. AGE: Years 60 | Months 0 | Days 11 | If less than one day ____ hr. ____ min.

9. Birthplace Europe (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Anton Skrivanek
13. Birthplace Austria

MOTHER
14. Maiden Name Mary Hladik
15. Birthplace Austria

16 (a) Informant Eug. Kozlovsky
(b) Address 2116 Ashland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 2 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director Edward Kracht Son
(b) Address 900 N. Chester St.

19 (a) [illegible] Registrar

MAY 1 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28, 1947, at 2:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2, 1947 to Apr. 28, 1947, and that I last saw her alive on Apr. 28, 1947.

Immediate cause of death: Respiratory Failure — Duration: ____

Due to: Toxicity — Duration: ____

Due to: Generalized Carcinomatosis — Duration: 4 mos

Other Conditions: ____ — Duration: ____

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation: None

of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Anthony F. DiPaula
Address St. Josephs Hosp. Date signed 4/29/47 (M D)

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51212

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G51212 ✓ 13a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 902 Eastern Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 - 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 902 Eastern Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Varella

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	Married

6 (b) Name of husband or wife XXXXX Antonio Varella
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15 1872

8. AGE: Years	Months	Days	If less than one day
74	9	14	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Frank Poggi
13. Birthplace Italy

MOTHER
14. Maiden Name Theresa ?
15. Birthplace Italy

16 (a) Informant Madeline Varella (Daughter)
(b) Address 902 Eastern Ave

17 (a) Burial (b) Date thereof May 3rd/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rose
(b) Address 52 N. Morley St.

19 (a) MAY 1 - 1947 Huntington Williams, M.D. Registrar
(Date of city registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-28-47 19 , at 8.20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-2-47 19 , to 4-28- 1947.
and that I last saw h.r alive on 4-28- 19 47

Immediate cause of death Coronary Occlusion — Duration 4 mos.
Due to Hypertension — yrs ?
Due to Interstitial Nephritis — yrs ?
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S. Demarest M.D.
Address Medical Arts Bldg. Date signed 4/30/47

correct age is especially important. Physicians: please write the

VS 150

X

G51243

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G51243

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 307 S.High St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 307 S.High St. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Dora Stegner

3 (b) If veteran, name war none
3 (c) Social Security Account No. none

4. Sex female
5. Color or race white
6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 16 1869

8. AGE: Years 77 Months 8 Days 14 24 If less than one day ... hr. ... min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation House Keeper

11. Industry or business

FATHER
12. Name ?
13. Birthplace /?

MOTHER
14. Maiden Name Ida ?
15. Birthplace ?

16 (a) Informant John Votta
(b) Address 307 S.High St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 3rd/47 (month) (day) (year)
(c) Cemetery [illegible]rinity
Location O'Donnell st.

18 (a) Funeral director Frank Della Vedova
(b) Address 52 N.Morley St.

19 MAY 1 - 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-30- 1947 at 10.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-8- 1947 to 4-30 1947 and that I last saw h[illegible] alive on 4-26 1947

Immediate cause of death coronary occlusion - — Duration 20 dys

Due to arteriosclerosis — ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

Signature [illegible]

Address medical arts Bldg Date signed 4/30/47

VS 130

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51244 Dr. Hirschfeld
6919 Harford Road

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131a

Registered No. G51244

Please write the causes of death clearly and legibly. Use only standard abbreviations. Underlying cause is especially important. Physicians: please write as required.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7000 Harford Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 7000 Harford Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George F. Schnabel

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Anna S.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1872

8. AGE: Years	Months	Days	If less than one day
74	5	20	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name August F. Schnabel
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Anna S. Schnabel
(b) Address 7000 Harford Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/3/47 (month) (day) (year)
(c) Cemetery or crematory St. Paul's Cem.
Location Baltimore, Md.

18 (a) Funeral director Leohard J. Ruck
(b) Address 5305 Harford Road

19 MAY 1 1947 (b) Huntington Nitzsche

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 30th, 1947, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1947, to April 30 1947, and that I last saw h IM alive on 4/29/1947.

	Duration
Immediate cause of death UREMIA	6 days.
Due to Hypertensive Cardio-Renal disease	9 mos.
Due to	
Other Conditions Arteriosclerosis.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul A. Hirschfeld M.D.
Address 6919 Harford Rd Date signed 5/1/47

G51245 Zimmerman
2858 Harford Road

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. G51245

Please write the causes of death clearly and legibly. Physicians: please write in especially important. Use necessary supplies.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5505 Pioneer Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
Street No. 5505 Pioneer Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie B. Baer

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
famale	white	widowed

6 (b) Name of husband or wife John Baer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 17 1867

8. AGE: Years	Months	Days	If less than one day
79	4	9 13	hr. min.

9. Birthplace Green Castle, Pa.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Columbus Pentz
13. Birthplace Pa.

MOTHER
14. Maiden Name Susan Ziegler
15. Birthplace Pa.

16 (a) Informant Mrs. Elmer P. Volke
(b) Address 5505 Pioneer Drive, 14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/3/47 (month) (day) (year)
(c) Cemetery or crematory Cedar ~~Grove~~ Hill
Location Green Castle, Pa.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 MAY 1 1947 (Registrar) Washington, D.C.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1946 to April 30 1947, and that I last saw her alive on 30 April 1947.

Immediate cause of death	Duration
Cerebral anoxia	
Due to Cerebro-vascular accident	9 wks
Due to Arterio-Sclerotic cardio-vascular disease	10 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Roy M. Zigmond M. D.
Address 5350 Harford Rd Date signed 30 April 47

X

51246

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G51246

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Perryman
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Jay Ferdinand Towner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mrs. Jay Ferdinand Towner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19 1883

8. AGE: Years 63 | Months 10 | Days 12 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name J. F. Towner
13. Birthplace Maryland

MOTHER
14. Maiden Name Gertrude Bonn
15. Birthplace New York

16 (a) Informant Mrs. Jay Ferdinand Towner
(b) Address Perryman, Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof May 4 1947 (month) (day) (year)
(c) Cemetery or crematory Spesutie
Location Perryman Md

18 (a) Funeral director Henry Fanning Sons
(b) Address Chesden Md

19 (a) MAY 7 1947 (Date received by registrar) (b) Wilson Millington MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-1 1947, at 4.55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 27 1947 to May 1 1947 and that I last saw h[illegible] alive on May 1 1947

Immediate cause of death: Ventricular fibrillation
Pulmonary edema
Due to [redacted]
Due to Hypertension
Due to Cardiovascular disease

Other Conditions: Bronchopneumonia
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
4-5 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman R. Freeman M. D.
Address Union Memorial Hospital Date signed May 1, 47

X

51247

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X ✓ 55E

Registered No. G51247

Please write the causes of death clearly and legibly. Physicians: please write correct age if especially important. Do not use abbreviations or symbols. Use ordinary language.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edmondson Ave
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Dorchester
(c) City or town Cambridge (If outside city or town limits, write RURAL and give town)
(d) Street No. 318 Locust St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Edmondson

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife John F.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 26, 1872

8. AGE: Years	Months	Days	If less than one day
75	1	5	hr. min.

9. Birthplace Dorchester Co. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Robert L. Marshall
13. Birthplace Dorchester Co. Md.

MOTHER
14. Maiden Name Margaret Elliott
15. Birthplace Dorchester Co. Md.

16 (a) Informant Mrs. Vivian Mann
(b) Address 318 Locust St. Cambridge Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/3/47 (month) (day) (year)
(c) Cemetery or crematory
Location Cambridge Md.

18 (a) Funeral director Wm. B. Tuttle & Son
(b) Address No. 4 N. Eutaw St. Balt. Md.

(a) MAY 2 - 1947 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-1 1947, at 7:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-27 1947 to 5-1 1947, and that I last saw h[illegible] alive on 5-1 1947

Immediate cause of death	Duration
Due to Intestinal Obstruction	
Due to Primary Peritonitis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 5-7-47

51218 OH# 6-74486

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 64

✓ G51218 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important. Use only accepted medical terminology. Abbreviations should not be used.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2112 N. Calvert Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2112 N. Calvert Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SHARAN LEE MYERS

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 22, 1947

8. AGE: Years 0 | Months 1 | Days 9 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Jack Preston Myers
13. Birthplace W. Va.

MOTHER
14. Maiden Name Opal May
15. Birthplace W. Va.

16 (a) Informant James P. Myers
(b) Address 1501 N. Hilton Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 2, 1947 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Parkville (Balto. Co.) Md.

18 (a) Funeral director William Cook, Inc.,
(b) Address 1217 St. Paul Street

MAY 2 - 1947 (Date rec'd by Registrar) Hunter for Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1947, at 2.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 22 1947, to May 1 1947, and that I last saw her alive on April 30 1947.

Immediate cause of death	Duration
Hypertrophy of Thymus Gland	1 Mo.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Conrad Lindon M. D.
Address 2201 W. North Ave Date signed 5-1-47

X

51249

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G51249
Registered No.

CERTIFICATE OF DEATH 53

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) ~~Hospital or~~ institution: Elmhurst Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Balto (Brooklyn)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 123 Meadow Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lewin H. Jacobs

3 (b) If veteran, name war W
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or divorced.
Male	White	Widowed

6 (b) Name of ~~husband or~~ wife Margaret Jacobs
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 2nd 1860

8. AGE: Years	Months	Days	If less than one day
86	5	27	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Stone Cutter

FATHER
12. Name ? Jacobs
13. Birthplace Pa.

MOTHER
14. Maiden Name Unknown
15. Birthplace Pa.

16 (a) Informant John H. Jacobs
(b) Address 4650 Pimlico Rd.

17 (a) Burial (b) Date thereof 5/2/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

MAY 2 - 1947
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29th 1947, at 8:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1944 to Apr 29 1947, and that I last saw h. alive on Apr 26 1947.

Immediate cause of death	Duration
Coronary occlusion	
Due to Hypertension	
Due to	
Other Conditions Carcinoma of Face	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Pw Kistler MD
Address 302 Patapsco Av Date signed Apr 30 1947

VS 150

94a

...ce, write the causes of death clearly and legibly. Physicians: please write ... age is especially important.

G51250

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. G51250

BCH # 972017

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) DA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3524 Horton Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Albert Martin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb 21. 1947

8. AGE: Years | Months: 2 | Days: 10 | If less than one day: hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Albert Martin
13. Birthplace: Va.

MOTHER
14. Maiden Name: Martha Howell
15. Birthplace: Md.

16 (a) Informant: Albert Martin
(b) Address: 3524 Norton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/3/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Glen Haven
Location: A. A. Co. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 127 St. Paul Street

MAY 2 - 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/1/47 19 , at 5:45A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Congenital Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D. Medical Examiner.

Date signed 5/1/47

51251 28-1 BALTIMORE CITY HEALTH DEPARTMENT 937 G51251

CERTIFICATE OF DEATH

Registered No.

Please write plainly in ink or use typewriter. Entries must be complete and correct as directed on other side. Do not use abbreviations. If unknown, or not applicable, write none. Physicians: please write the cause of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6512 Park Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6512 Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara E Stonesifer

3 (b) If veteran, name war: W

3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Andrew F

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1867

8. AGE: Years 79 | Months 8 | Days | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Stepard
13. Birthplace Md

MOTHER
14. Maiden Name Barbara Risner
15. Birthplace Md

16 (a) Informant Vernon Stonesifer
(b) Address 6512 Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/3/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Md

18 (a) Funeral director Wilson Cook Son
(b) Address 1214 N Paul St

MAY 2 - 1947 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1947, at 9:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1947, to April 30 1947, and that I last saw h.e.r. alive on April 30 1947.

	Duration
Immediate cause of death: Arteriosclerotic Heart Disease	6 mos.
Due to:	
Due to:	
Other Conditions: Gastric Tumor - hypertension	3 mos.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. E. Lawson M. D.
Address 4843 Parkheights Ave Date signed 5-5-47

G51252

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

Registered No. G51252

Every item of information should be carefully supplied. Type or write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1714 Chesapeake Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1714 Chesapeake Ave (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Jenkins

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col	married

6 (b) Name of husband or wife Fred Jenkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 3 1883

8. AGE: Years	Months	Days	If less than one day
63	10		hr. min.

9. Birthplace Pitts Co N.C. (Town, county, and State)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Eddie Worden
13. Birthplace Pitts Co, N.C.

MOTHER
14. Maiden Name Sarah Barrett
15. Birthplace Pitts Co N.C.

16 (a) Informant Fred Jenkins
(b) Address 1714 Chesapeake Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 1-1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location A. A. Co Md.

18 (a) Funeral director Robt E Williams
(b) Address 15-15 McElderry St
MAY 2 - 1947 (Date rec'd by local registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28 1947 at 7 A M
21. I certify that death occurred on the date above stated; that I attended deceased from April 1947 to April 28 1947 and that I last saw him alive on April 27 1947.
Immediate cause of death Cerebral Hemorrhage 2 hrs
Duration
Due to Hypertension 2 years
Due to
Other Conditions Negro Female
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work (Specify type of place)
(e) Means of injury
23. Signature Robt L Ward M. D.
Address 700 Huntington Date signed 5/7/47

VS 150

51253

AB-23031

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G51253

Registered No.

Please write the causes of death clearly and legibly. The correct age is especially important. Physicians: please write carefully supplied.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9yrs-9mos-13days

(e) Length of stay in Baltimore (yrs., mos., or days) 59yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2623 Ashland Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anton Chalus

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 13- 1868

8. AGE: Years	Months	Days	If less than one day
78	9	15	hr. min.

9. Birthplace Bohemia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER — 12. Name Charles

13. Birthplace Bohemia

MOTHER — 14. Maiden Name Annie

15. Birthplace Bohemia

16 (a) Informant Records-Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/2/47 (month) (day) (year)

(c) Cemetery or ~~Crematory~~ Oak Hill

Location Horner's Lane, Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek

(b) Address 2601-03 E. Madison Street

19 (a) MAY 2 - 1947 (Date rec'd by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28 1947, at 1.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-15- 1937 to 4-28 1947, and that I last saw h. im alive on 4-28- 1947.

Immediate cause of death	Duration
Pneumonia	Days
Due to	
Due to	over
Other Conditions Generalized Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Edmund B Carlson M. D.

Address Balto City Hosp. Date signed 3 Apr 47

X

51254

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. C51254

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 68 S. Franklintown Road
(c) Hospital or institution: **********
(d) Length of stay in hospital or inst. (yrs., mos., or days) *****
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 68 S. Franklintown Road (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME MINNIE M. LONG

3 (b) If veteran, name war ********
3 (c) Social Security Account No. *********

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Charles Long
6 (c) If alive, give age D. years
7. Birth date of deceased (mo., day, yr.) Jan. 11, 1876
8. AGE: Years 71 | Months 3 | Days 18 | If less than one day **********min.
9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Charles Graubner
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Alice A. Smith
(b) Address 68 S. Franklintown Road
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 2, 1947 (month) (day) (year)
(c) Cemetery or crematory Oaklawn Cemetery
Location Baltimore County Md.
18 (a) Funeral director P. F. Wisbert & Son
(b) Address 1300 Eutaw Place
(c) Date received by registrar MAY 2 - 1947 (b) Registrar [illegible]

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29th. 47 19** at 6:45 AM
21. I certify that death occurred on the date above stated; that I attended deceased from 11/10 1936 to 4/29 1947 and that I last saw her alive on 4/28 1947

Immediate cause of death: Uremia — Duration: 4 days
Due to: Cardio-Vascular Renal Disease — 15 Months
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:
23. Signature Elisabeth W. Johnson M. D.
Address 3437 Frederick Ave Date signed

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51255

G51255

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 221 N. Fremont Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 221 N. Fremont Av.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Walter Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	C	married

6 (b) Name of husband or wife Fannie Johnson.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 12, 1899

8. AGE: Years	Months	Days	If less than one day
47	6	17	hr. min.

9. Birthplace Blackstocky S.C.
(Town, county, and state)
10. Usual Occupation Laborer.
11. Industry or business

FATHER
12. Name Henry Johnson
13. Birthplace Blackstock, S.C.

MOTHER
14. Maiden Name Julia Caldwell
15. Birthplace Blackstone, S.C.

16 (a) Informant Fannie Johnson.
(b) Address 221 N. Fremont Ave

17 (a) Burial (b) Date thereof May 3 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Blackstocky S.C.

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Lafayette Ave
for Williams, Mortician

19 (a) Filed (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/24-47 19 , at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/2 19 47 to 4/26 19 47, and that I last saw h[illegible] alive on 4/26 19 47

Immediate cause of death	Duration
Carcinoma	
Due to Stomach ? metastasis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place) BM RHETTA
(e) Means of injury
23. Signature B W R Watts M. D.
Address 179 W. N. Ave. Date signed 4/26/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G51256

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G51256

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division st.
(c) Hospital or institution:
Provident
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DEACEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 501 Carlton st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Irving Charles Cross

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/12/90

8. AGE: Years	Months	Days	If less than one day
56	8	17	hr. min.

9. Birthplace Arundel Co. Md.
(Town, county, and state)
10. Usual Occupation Stevedore
11. Industry or business

FATHER
12. Name Charles H. Gross.
13. Birthplace West River, A. A. Md.

MOTHER
14. Maiden Name Victoria Estep.
15. Birthplace West River A.A. Md.

16 (a) Informant Esther Topgood.
(b) Address 298 N. Schroeder st.

17 (a) Burial (b) Date thereof May 4 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location West River A.A. Co. Md.

18 (a) Funeral director Mrs Kate K. Williams
(b) Address 322 N Schroeder St

19 (a) MAY 2 - 1947 Huntington Williams, Registrar
(Date filed by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/29 1947 at 9:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/20 1947 to 4/29 1947 and that I last saw h[illegible] alive on 4/29 1947.

Immediate cause of death Hypertensive Cardio-Vascular Renal Disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. E. Barfield M.D.
Address Provident Hosp. Date signed 4/29/47
M. D.

5257

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G51257

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important. Penalty for refusal or neglect to supply information required by law or for wilfully supplying false information, $5.00 to $100.00 fine. Sec. 195

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 213 N. Carrollton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 213 N. Carrollton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elenora G. Skinner.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1, 1886

8. AGE: Years	Months	Days	If less than one day
60	8	29	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name James Skinner
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Amanda Fuller
15. Birthplace Baltimore, Md.

16 (a) Informant Evelyn Johnson
(b) Address

17 (a) Burial (b) Date thereof May 3, 1937
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs. Hattie R. Willis
(b) Address 322 N. Schroeder St.

19 (Date rec'd by registrar) MAY 2 - 1937 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1937, at 8:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 26 1937, to April 30 1937, and that I last saw her alive on April 29 1937.

Immediate cause of death	Duration
Cerebral Hemorrhage	4 dys.
Due to Hypertension and Arteriosclerosis	
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Wallis Sherman M.D.

Address 201 N Carey St. Date signed 5/1/37

VS 150

G51258

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 59B

Registered No. G51258

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 405 N. Carrollton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 405 N. Carrollton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Humbert

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	married

6 (b) Name of husband or wife John Humbert
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2, 1901

8. AGE: Years	Months	Days	If less than one day
45	9	29	hr. min.

9. Birthplace Norfolk, Virginia
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thomas Bailey.
13. Birthplace Surry Co., Va.

MOTHER
14. Maiden Name Rebecca Woodley
15. Birthplace Surry Co. Va.

16 (a) Informant Rebecca Bailey
(b) Address 405 N. Carrollton.

17 (a) Burial (b) Date thereof May 5, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Watkins
(b) Address 322 N. Schroeder St

19 MAY 2 - 1947 Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1947, at 2A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 27 1947 to May 1 1947, and that I last saw Dec. alive on April 31 1947.

Immediate cause of death	Duration
Congestive heart failure	2-3 hours
Due to Unknown	
Due to Unknown	
Other Conditions Multiple Fibroids and Interstitial hysterectomy	Years

(Include pregnancy within 3 months of death)

Date of operation April 28
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George McDonald, M.D.
Address 844 N. Grey Date signed 5/2/47

259

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G51259 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 243 Pearl St
(c) Hospital or institution: 4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 243 Pearl St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel B. Lee.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary E. Lee

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23, 1891.

8. AGE: Years: 55 | Months: 10 | Days: 7 | If less than one day: hr. min.

9. Birthplace Hartford Co., Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Edward Lee.
13. Birthplace Hartford Co., Md.

MOTHER
14. Maiden Name Jenson.
15. Birthplace Hartford Co. Md.

16 (a) Informant Mary E. Lee
(b) Address 243 Pearl St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 3, 1947 (month) (day) (year)
(c) Cemetery or crematory
Location Abingdon, Hartford Co. Md.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) MAY 2 1947 (Date rec'd by registrar) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1947, at 4 P M

21. I certify that death occurred on the date above stated, that I attended deceased from April 25 1947 to April 30 1947 and that I last saw h[illegible] alive on April 30 1947

Immediate cause of death: Uremia

Duration: 6 ds

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address [illegible] Date signed 5/2/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

L260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. G51260

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1125 N. Carrollton ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Artis Davis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4 Sex: Female | 5 Color or race: Black | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~

6 (b) Name of husband or wife: Miles Davis
6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) 6-10-08

8. AGE: Years 38 | Months — 10 | Days — 19 | If less than one day — hr. — min.

9. Birthplace So. Carolina (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER 12. Name James Barnouth
13. Birthplace So. Carolina

MOTHER 14. Maiden Name Mary Weatherly
15. Birthplace So. Carolina

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Disposal Shipping (Burial, cremation, or removal) (b) Date thereof May 3, 1947. (month) (day) (year)
(c) Cemetery or crematory
Location Camden S.C.

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St

19 MAY 2 - 1947 Huntington Williams M.D. (Date filed by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-29-1947, at 7:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-28-1947, to 4-29-1947, and that I last saw her alive on 4-29-1947.

	Duration
Immediate cause of death Uremia	
Due to CARCINOMA CERVIX recurrent	
Due to	
Other Conditions X-ray radium treatment	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Josephine E Rimstead M. D.
Address Johns Hopkins Hosp Date signed 4/30/47

X

G51261

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Registered No. G51261

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3202 Bayonne Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2?
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3202 Bayonne Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ottilie Tober

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Frederick Tober

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1 1878

8. AGE: Years 68 | Months 11 10 | Days 1 | If less than one day ....hr. ....min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Frederick Muntz
13. Birthplace Germany

MOTHER
14. Maiden Name Julia Lieshner
15. Birthplace Germany

16 (a) Informant Mr Gustav Tober
(b) Address 3202 Bayonne Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/3/47 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial
Location Baltimore

18 (a) Funeral director Lashaw Funeral Home
(b) Address 7401 Belair Rd Balto 6 Md

MAY 2 - 1947 (Date rec'd by local registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1947 19 1:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1946 to May 1 1947 and that I last saw h[illegible] alive on April 30 1947.

Immediate cause of death: Carcinoma of Pancreas — Duration: 1 year

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: May & July 1946

Major findings of operation: Cancer of Pancreas Cholecystitis

of autopsy: None

PHYSICIAN
Underline the [illegible] which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: No
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? None While at work? (Specify type of place)
(e) Means of injury None

23. Signature R. K. Grady M.D.

Address 5106 Harford Rd Date signed 5/6/47

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51262

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G51262

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3310 Leighton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Levi, Robert Solomon Silver

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 67 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name David Poland
13. Birthplace

MOTHER
14. Maiden Name Dora Poland
15. Birthplace

16 (a) Informant Rose Silver
(b) Address 3310 Leighton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-2-47 (month) (day) (year)
(c) Cemetery or crematory Shaare Tefloh
Location Windsor Mill Road

18 (a) Funeral director Jacob Lewis Inc
(b) Address 429 E Balto St

19 MAY 2 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1, 1947, at 6:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 6 1947, to May 1 1947, and that I last saw him alive on May 1, 1947.

Immediate cause of death	Duration
Cardiac failure	
Due to Arteriosclerotic heart disease	
Due to Generalized arteriosclerosis	
Other Conditions Healed TBC	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sidney Greenberg M. D.
Address Sinai Hospital Date signed 5/1/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any item of information should be carefully supplied.

51263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

G51263 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4622 Leaderstown Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 8
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give county)
(d) Street No. 4622 Leaderstown Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Echael Carton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed or divorced: Married

6 (b) Name of husband or wife: Esther

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 79 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Hyman
13. Birthplace Russia

MOTHER
14. Maiden Name Tobie
15. Birthplace Russia

16 (a) Informant Esther Carton
(b) Address 4622 Leaderstown Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-2-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E Baltimore St

19 MAY 2 - 1947 (Date rec'd by local registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-2 1947 at 10:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-15 1946 to 5-1-1947 and that I last saw him alive on 5-1-1947.

Immediate cause of death Carcinoma of lower lobe of rt. lung. | Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3-6-47

Major findings of operation: Cancer of lower lobe rt. lung

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. A. Michelson M. D.
Address 2230 Eutaw Pl. Date signed 5/2/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

5 1264

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133B

Registered No. C51264

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave
(c) Hospital or institution Sinai Hospital b

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 33yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 116 N. Wellington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Haman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Irving Morris Haman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1891

8. AGE: Years 56 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Poth (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name —
13. Birthplace Poth

MOTHER
14. Maiden Name —
15. Birthplace Poth

16 (a) Informant Irving M. Haman
(b) Address 116 N. Wellington Ave

17 (a) Sinai (Burial, cremation, or removal) (b) Date thereof 5-2-47 (month) (day) (year)
(c) Cemetery or crematory Pikesdale
Location

18 (a) Funeral director Jack Levine Inc.
(b) Address 1439 E. Balto St

MAY 2 - 1947 (Date rec'd by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/1/47 19..., at 7:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/25/47 19... to 5/1/47 19..., and that I last saw her alive on 5/1/47 19...

	Duration
Immediate cause of death: Uremia	6 days
Due to: Polycystic Kidney Disease	Life
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation 4/29/47

Major findings of operation: Polycystic Kidney

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Asher Hollander M. D.
Address Sinai Hospital Date signed 5/1/47

X

51265

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52B

Registered No. C51265

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3018 Presstman St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3018 Presstman St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY FLORENCE LANE

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Bernard O. Lane
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 11, 1866

8. AGE: Years	Months	Days	If less than one day
80	7	19	hr. min.

9. Birthplace New Jersey
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name - Wirgley
15. Birthplace Unknown

16 (a) Informant Mrs. Hester Sansbury, daughter
(b) Address Friendship, A. A. Co., Md.

17 (a) Burial (b) Date thereof 5/3/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto;, Md.

19 (a) MAY 2 - 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30, 1947 at 2:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 24 1946, to Apr 30 1947. and that I last saw h[illegible] alive on Apr 29 1947.

Immediate cause of death	Duration
Due to Carcinoma of Bladder	
& pelvic adenitis.	3-4 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Barnwood M. D.
Address 2200 Garrison Blvd Date signed 5-1-47

VS 150

correct age is especially important. Physicians: please write the

1266

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C51266

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3008 N. Calvert St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3008 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA L. TROTTER

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John R. Trotter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 14, 1883

8. AGE: Years	Months	Days	If less than one day
63	8	16	hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Henry Schuchardt
13. Birthplace: Germany

MOTHER
14. Maiden Name: Katherine Wills
15. Birthplace: Germany

16 (a) Informant: Mrs. Anna Bailey
(b) Address: 1616 Bolton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/3/47 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Balto., Md.

19 (a) MAY 2 - 1947 (Date rec'd by registrar) (Registrar's signature illegible)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30, 1947, at 7:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1947 to April 30 1947, and that I last saw h alive on April 29 1947.

Immediate cause of death: Coronary Thrombosis — Duration: 1-2 hrs.
Due to: Hypertension C V D & Arterio Sclerosis — 2
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:
23. Signature: Laurence J. Hamanche
Address: 3711 Falls Rd. Date signed: M. D. 5-7-47

VS 150

correct age is especially important. Physicians: please write the

51267.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 583

G51267 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 N. Calvertow Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 22 N. Calvertow Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marvell Virginia Haas

3 (b) If veteran, name war —
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	Married

6 (b) Name of husband or wife Henry Haas
6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) Jan. 10, 1916

8. AGE: Years	Months	Days	If less than one day
31	3	19	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Rudolph Stangler
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mattie Mason
15. Birthplace North Carolina

16 (a) Informant Mrs. Henry Haas
(b) Address 22 N. Calvertow Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 3/94 (month) (day) (year)
(c) Cemetery or crematory Westend
Location Baltimore

18 (a) Funeral director Frederick A. Cole
(b) Address 1700 W. Lombard

Date Received MAY 2 - 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1947, at 1:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1947 to April 29 1947 and that I last saw her alive on 4/29 1947.

Immediate cause of death	Duration
(a) Acute Stenosis Insufficiency	6 yrs
Due to (b) Mitral Stenosis	
Due to (c) Rheumatic Heart	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas A Barker
Address 2145-W Belv Date signed 5/1/47

MAY 2 - 1947

Please write the causes of death clearly and legibly. Physicians: please write. Exact age is especially important. Physicians: please write.

G51268

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G51268

Please answer all questions in ink. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Franklin Square
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 A
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1049 Vine St
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Bessie Romes (Roane)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1945

8. AGE: Years	Months	Days	If less than one day
5y			hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation domestic

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Lydia B. Chase
(b) Address 638 N. Gilmor St

17 (a) B (Burial, cremation, or removal) (b) Date thereof 5-5-47 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location City

18 (a) Funeral director Samuel W. Sullivan & Sons
(b) Address 1011 N. Eutaw St

MAY 2 - 1947 (Date rec'd by registrar) (b) Huntington for Williams, Mgr

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/1/47, 19..., at 4:17 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Guy R. D. Ayres M.D.
Medical Examiner.
Date signed 5/1/47

51269

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G51269
Registered No.

READ WITH CARE, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2319 Division St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2319 Division St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) **FULL NAME** Minnie T. Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29, 1880

8. AGE: Years 67 | Months 9 | Days 1 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Laundress

11. Industry or business

FATHER
12. Name Robert Taylor
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Reed
15. Birthplace Maryland

16 (a) Informant Viola Summerville
(b) Address 2319 Division St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/3/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemet.
Location Cedar Hill Md.

18 (a) Funeral director A. Hallodd
(b) Address 918 Druid Hill Ave.

19 MAY 2 - 1947 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/30 - 19 47

21. I certify that death occurred on the date above stated; that I attended deceased from 4/21 19 47, to 4/30 19 47, and that I last saw h. alive on 4/26 19 47

Immediate cause of death Cause - a Stroke — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 4/24/47

Major findings of operation:

as above

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Burkett M. D.
Address 324 N. Eutaw Date signed 4/30 19 47

VS 150

G51270

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G51270

correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring x Belvedere Aves.
(c) Hospital or institution: Levindale Hebrew Home x Infirmary 5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 211 N. High Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME KATIE ROSS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Wallie Ross
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1874

8. AGE: Years 73 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name —
13. Birthplace Russia

MOTHER
14. Maiden Name —
15. Birthplace Russia

16 (a) Informant Mrs. Annie Friedenberg
(b) Address 200 N. High St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-2-47 (month) (day) (year)

(c) Cemetery or crematory Rosedale
Location

18 (a) Funeral director Dor Levine Inc
(b) Address 1439 E. Balto St

19 [illegible] 2 [illegible] 1947 (b) [illegible] Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-2 1947, at 3:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-14 1947 to 5-2 1947 and that I last saw h alive on 1947.

Immediate cause of death Bronchopneumonia bilateral — Duration

Due to

Due to

Other Conditions Gangrene of r leg cerebral hemorrhage
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Boyd M. D.
Address Levindale Home Date signed 5-2-47

VS 150

107

G51271

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1084

Registered No. G51271

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Union Memorial Hosp. 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 406 N. Pine St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) **FULL NAME** Thomas Frost

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Nellie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years 54 | Months | Days | If less than one day .....hr. .....min.

9. Birthplace Marksville N.C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Richard Frost
13. Birthplace N.C.

MOTHER
14. Maiden Name Elinia Smoot
15. Birthplace N.C.

16 (a) Informant Nellie Frost
(b) Address 406 N. Pine Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 4, 1947 (month, day, year)
(c) Cemetery or crematory.....
Location Marksville N.C.

18 (a) Funeral director A. Galstead
(b) Address 918 Druid Hill Ave.

19 (a) Date rec'd MAY 2 1947 (b) Huntington Williams M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30, 1947 at 3:45 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Valvular Heart Disease

Due to.....

Other Conditions Early Lobar Pneumonia.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature Earl L Royer M.D.
Medical Examiner.
Date signed 5-1-47

92D

51272

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G51272

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilson & Caton Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 625 N. Bend Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Clay Shawaker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elizabeth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 22 1869

8. AGE: Years	Months	Days	If less than one day
77	4	8	hrs. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Geo. W.
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Elizabeth Shawaker
(b) Address 625 North Bend Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 3 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location 3801 Frederick Rd

18 (a) Funeral director Henry H. Wiltze
(b) Address 410 Edmondson Ave.

MAY 2 - 1947 (Date rec'd by Registrar) Hampton Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-30 1947 at 11:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-28 1947 to 4-30 1947 and that I last saw h/his alive on 4-30 1947

Immediate cause of death Heart Failure — Duration

Due to Cardio-Vascular-Renal Disease —

Due to

Other Conditions Terminal Pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hamilton Smith Symington M.D.

Address St. Agnes Hosp. Date signed 4/30/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51273

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1928

Registered No. G51273

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 343 Robert Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 343 Robert St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William A. Johnson

3 (b) If veteran, name war I W.W.

3 (c) Social Security Account No. 217-16-310

4. Sex male | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Divorced

6 (b) Name of husband or wife Martha S.

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) June 5, 1890

8. AGE: Years 56 | Months 10 | Days 25 | If less than one day hr. min.

9. Birthplace King and Queen Co Va.
(Town, county, and state)

10. Usual Occupation Messenger

11. Industry or business

FATHER
12. Name William W. Johnson
13. Birthplace King and Queen Co, Va.

MOTHER
14. Maiden Name Fannie L. Saunders
15. Birthplace Caroline Co, Va.

16 (a) Informant Susie Smith
(b) Address 1929 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/4/47 (month) (day) (year)
(c) Cemetery or crematory Caroline
Location Caroline Co, Va.

18 (a) Funeral director Meg. W. Gibson
(b) Address 1303 Pennsylvania Ave

19 (Registrar's signature) MAY 2 — 1947 Registrar by Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1947, at 3 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 25 1947, to Apr 30 1947, and that I last saw h[illegible] alive on Apr 29 1947.

Immediate cause of death Cerebral Hemorrhage — Duration 2 hrs

Due to Mitral Insufficiency — Duration 1 yr

Due to Hypertension — Duration 1 yr

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Edward Fisher M. D.

Address 1612 E Monument St Date signed 5/5/47

VS 150

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G51274

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 53

G51274 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 3 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 40 Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4016 Ridgecroft Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Wolters

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race W White

6 (a) Single, married, widowed, or divorced. ?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/15/1867

8. AGE: Years 79 Months 6 Days 16 If less than one day hr. min.

9. Birthplace Denmark (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name ?

13. Birthplace

MOTHER 14. Maiden Name ?

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 3 1947 (month) (day) (year)

(c) Cemetery or crematory St Johns Location Ellicott City

18 (a) Funeral director Grand H. Seitz

(b) Address 814 N 36th St

19 (a) MAY 2 1947 (Registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1947 at 3:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 26 1947 to May 1 1947 and that I last saw h. alive on May 1 1947

Immediate cause of death Cardiorespiratory failure — Duration

Due to Subarachnoid hemorrhage

Due to Arteriosclerotic Cardiovasc. disease

Other Conditions Left inf. hernia ? epidermoid Ca. of nose

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sidney Green M.D.

Address Sinai Hospital Date signed May 2 1947

V S 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51275

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G51275

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1303 Patapsco St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Yr
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1303 Patapsco St. (If rural give location)
(e) Citizen of foreign country? — (Yes or No) If yes, name country

3 (a) FULL NAME Mary Annie Louise Ruppel

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John H. Ruppel

6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) July 11, 1882

8. AGE: Years 64 | Months 9 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housewife —

11. Industry or business —

FATHER 12. Name Andrew Kraft

13. Birthplace Germany

MOTHER 14. Maiden Name Annie E. Walters

15. Birthplace Baltimore Md.

16 (a) Informant John H. Ruppel (Husband)

(b) Address 1303 Patapsco St. Balto 30

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 3, 1947 (month) (day) (year)

(c) Cemetery or crematory London Park Cem.

Location Balto., Md.

18 (a) Funeral director Pickerwood & Evans

(b) Address 1600 S. Charles St., Balto 30 Md.

19 MAY 2 - 1947 (Date rec'd by reg.) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30, 1947, at 11:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 25 1947 to April 30 1947 and that I last saw h alive on April 6 1947

Immediate cause of death: Pneumonia Lobar type

Due to: Coronary Occlusion

Due to: arteriosclerosis

Other Conditions

Duration: 5 days, 3 mos

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. F. Hawkins M. D.

Address 6 E. Randall St. Date signed 5/1/47

J. F. Hawkins X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G51276

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G51276

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2316 Sidney Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2316 Sidney Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James T. Adams

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-16-4817

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife (nee Russell) Bertie Adams
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) August 25, 1877

8. AGE: Years	Months	Days	If less than one day
69	8	5	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired Plasterer

11. Industry or business

FATHER 12. Name ? Adams
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Mary ?
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Myrtle L. Prehoff (Daughter)
(b) Address 2316 Sidney Ave., Balto. 30, Md

17 (a) Burial — (b) Date thereof May 3, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director C. Howard Evans
(b) Address 1005 S. Charles St., Balto. 30, Md.

19 (a) MAY 2 - 1947 (Date rec'd by registrar) Investigator Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30, 1947, at 8:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 1 1947 to 4/30 1947, and that I last saw him alive on 4/30 1947

Immediate cause of death arteria sclerosis
Due to heart disease

Duration 1 mo.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of surgery:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M.D.
Address 2030 Wilkens Ave. Date signed 5/1/47

VS 180

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51277

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 587

Registered No. G51277

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Laynes & Dudeland
(c) Hospital or institution: West Baltimore
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2739 W Layfayette Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Watson Gabriel Jr

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1930

8. AGE: Years	Months	Days	If less than one day
17			hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation School
11. Industry or business

FATHER
12. Name Watson Gabriel
13. Birthplace Balto.

MOTHER
14. Maiden Name Adelphia Kampas
15. Birthplace Balto

16 (a) Informant Watson Gabriel
(b) Address 2739 W Lafayette

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 3 47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 3 Lain Rd

18 (a) Funeral director Joseph Kaminskas
(b) Address 604 Washington Blvd

19 MAY 2 - 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 April 1947, at 1:53 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 15 Oct. 1946 to 30 April 1947, and that I last saw h[im] alive on 30 April 1947.

Immediate cause of death	Duration
Cardiac Resp. Failure	
Due to Active Rheumatic Carditis	
Due to Rheum. Fever.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

Signature Lester A. Hall M. D.
Address West Balto Gen Hosp Date signed 4/30/47

VS 150

G51278

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83B

Registered No. G51278

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1808 N. Chester Street
(c) Hospital or institution: 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 60 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1808 N. Chester Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph A. Selckmann

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: ?

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Josephine Eick
6 (c) If alive, give age: 58 years
7. Birth date of deceased (mo., day, yr.): Feb. 11, 1883
8. AGE: Years: 64 | Months: 2 | Days: 19 | If less than one day: ###### hr. ###### min.
9. Birthplace: Holland (Town, county, and state)
10. Usual Occupation: Carpenter
11. Industry or business: U.S. Goverment

FATHER
12. Name: Edward Selckmann
13. Birthplace: Germany

MOTHER
14. Maiden Name: Sophia Ruck
15. Birthplace: Germany

16 (a) Informant: August E. Selckmann
(b) Address: 1808 N. Chester Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/3/47 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Rd, Balto: Md.

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

19 (a) MAY 2 - 1947 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30th 19 47; at M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 3, 1947, to Apr. 30 1947, and that I last saw h[illegible] alive on Apr. 30 1947.

Immediate cause of death	Duration
Cerebral Hemmorhage	4 days
Due to Arteriosclerosis	10 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George J. Ruth
Address 28 W 25th St. Date signed 5-1-47 M. D.

V S 150

G51279

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G51279

correct age is especially important. Physicians: please write the ... or information should be carefully supplied. The ... the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3219 Sequoia Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 56 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3219 Sequoia Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Elliott

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-09-1254

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Emma L. Elliott

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16-1863

8. AGE: Years 84 | Months 3 | Days 14 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Co. Maryland (Town, county, and state)

10. Usual Occupation American Silk Co.

11. Industry or business Retired

FATHER
12. Name Edward Elliott
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie Smith
15. Birthplace Maryland

16 (a) Informant Mrs. Marie E. Gardiner
(b) Address 3219 Sequoia Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 3-1947 (month) (day) (year)
(c) Cemetery or crematory New Market
Location Maryland Line, Baltimore Co.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 MAY 2 - 1947 (Date rec'd by registrar) (b) [illegible] Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30- 1947, at 10-20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1st 1946 to April 30th 1947, and that I last saw h.. alive on April 30 1947.

Immediate cause of death: Heart Failure — Duration: 1 day

Due to: Myocarditis — Duration: 1 year

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. C. Poulton

Address 3909 Gamewell Blvd Date signed May 1 1947

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

651280
AB-110220

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93D

Registered No. 651280

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5days
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1014 Granby Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Frances Willax-or- George Willox

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 14- 1868 1873

8. AGE: Years 73 ~~74~~ ? Months ~~6~~ 2 Days ~~17~~ ? If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Anthony Willax-or-Willox
13. Birthplace Italy

MOTHER
14. Maiden Name Katherine ?
15. Birthplace Germany

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/3/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Nath Ave & Rose N.

18 (a) Funeral director Howard N. Bligh Jr
(b) Address 6009 Harford Road

19 MAY 2 - 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION PM

20. DATE OF DEATH May 1 1947, at 12.18 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-26 1947, to 5-1 1947, and that I last saw him alive on 5-1 1947.

Immediate cause of death: Respiratory failure

	Duration
Due to: Bronchopneumonia & Empyema.	
Due to:	
Other Conditions: A S C V D Thrombophlebitis (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation: Bronchopneumonia Empyema left Thrombophlebitis, common
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statis-

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W Doyle Walden M. D.
Address B. C. H. Date signed 5/2/47

107

G51281

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G51281

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 68 Market Place
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Coscia - Coscia Sr.

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: 218-14-5874

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Rae Coscia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/14/1890

8. AGE: Years 57 | Months - | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore - Md. (Town, county, and state)

10. Usual Occupation Restaurant owner

11. Industry or business

FATHER
12. Name Emanuel Coscia
13. Birthplace Italy

MOTHER
14. Maiden Name Anna Basset
15. Birthplace England

16 (a) Informant Rae Coscia
(b) Address same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 4 47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave Rd

18 (a) Funeral director Mark H. Duppler Sons
(b) Address 3755 Sam St

19 MAY 2 - 1947 (b) Huntington Williams jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1947, at 8 00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/30 1947 to 5/1 1947, and that I last saw him alive on 5/1 1947.

Immediate cause of death: Resp failure — Duration:

Due to: Subarachnoid hemorrhage 1 day

Due to: Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature August Keil

Address Mercy Hosp Date signed M 5 D 1 47

VS 150

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51282
AB-110297

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 124a

Registered No. G51282

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 200 S. East Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Hajewski, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Antoinette

6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Jan. 27- 1903

8. AGE: Years 44 | Months 3 | Days 13 3 | If less than one day ....hr. ....min.

9. Birthplace Maryland (Baltimore)
(Town, county, and state)

10. Usual Occupation Butcher

11. Industry or business

FATHER
12. Name John A. Hajewski
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Wachowiak
15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/5/47 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Road

18 (a) Funeral director J. F. Hadrowski & Sons
(b) Address 1848 Eastern Avenue

19 (a) MAY 2- 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 19 47, at 10.44 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-29- 19 47, to 4-30- 19 47, and that I last saw him alive on 4-30 1947.

Immediate cause of death	Duration
Exsanguination	4 Hrs
Due to Hemorrhage from Esophageal Varices	?
Due to Laennec's Cirrhosis	8 months
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.
Address Baltimore City Hosp. Date signed 5/1-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G51283

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

✓ G51283 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2004 Gough Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2004 Gough Street
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA LINDEMAN BOROWSKA

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Peter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 24, 1882

8. AGE: Years	Months	Days	If less than one day
64	4	7	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Household

11. Industry or business

FATHER
12. Name Thomas Lignowski
13. Birthplace Poland

MOTHER
14. Maiden Name Anna Borkowska
15. Birthplace Poland

16 (a) Informant Mrs. Helen Hammer
(b) Address 2004 Gough Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/6/47 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Road

18 (a) Funeral director M. J. Labrozzi & Sons
(b) Address 1808 Eastern Avenue

19 (a) MAY 2 - 1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1, 1947, at 5P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 14 1947, to May 1 1947, and that I last saw her alive on May 1 1947.

Immediate cause of death: Cardio - renal vascular disease with mild hypertension — Duration: years

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sigmund R. Nowak M. D.
Address 408 S. Patt. Ob. Gn. Date signed 5/2/47

VS 150

X

PLEASE WRITE IN INK. WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51284

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G51284

Every item of information should be carefully supplied. Be sure to write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 317 E 21st St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Baltimore
(c) City or town FREELAND
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROSE ANN HARTZELL

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEM	WHITE	WIDOW

6 (b) Name of husband or wife JOHN E HARTZELL
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) MARCH 5 1884

8. AGE: Years	Months	Days	If less than one day
63	1	26	hr. min.

9. Birthplace BALTIMORE MD (Town, county, and state)
10. Usual Occupation HOUSE WORK
11. Industry or business AT HOME

FATHER
12. Name JOS ROBERT AKERS
13. Birthplace VIRGINIA.

MOTHER
14. Maiden Name ROSE McABEE
15. Birthplace MARYLAND

16 (a) Informant MRS REGINA STIFLER
(b) Address 317 E 21st St

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof May 5 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location BALTO MD

18 (a) Funeral director Bernard C Harle
(b) Address 121 E West St

19 (Signature of local registrar) MAY 2 1947 Huntington Williamsport Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 1st 1947, at 11.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1945 to 1947.
and that I last saw h alive on May 1 1947.

Immediate cause of death: Coronary Thrombosis — Duration 30 min

Due to: arteriosclerosis — 1 year

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Egbert K. Mortimer Jr M. D.
Address 2706 St Paul St Date signed 5/2/47

VS 150

X

C51285

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

775

Registered No. C51285

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University 4

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 613 W. Baltimore (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Ryne

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	D

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25 1906

8. AGE: Years	Months	Days	If less than one day
40 40	5 26		hr. min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Michael Ryne
13. Birthplace U.S.

MOTHER
14. Maiden Name Ellen Cassidy
15. Birthplace U.S.

16 (a) Informant Family
(b) Address

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 5-3-47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Brooklyn, Md.

18 (a) Funeral director James Kelly Eiely
(b) Address 130 E. Lee St.

19 (a) MAY 2 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/1/47 19 , at 2:10 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Alcoholism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Evans M.D.
Medical Examiner.
Date signed 5/1/47

Write age in capitals. Physicians: please write the causes of death clearly and legibly.

C51286

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. C51286

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 901 Aisquith Street
(c) Hospital or institution:
Convent of Notre Dame 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 26 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 901 Aisquith
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sr. M. Petra Nolasco Mary Puetz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 11 1867

8. AGE: Years	Months	Days	If less than one day
79	6	21	hr. min.

9. Birthplace Decada, Wisconsin
(Town, county, and state)

10. Usual Occupation Teacher

11. Industry or business Religious

FATHER
12. Name Henry Puetz
13. Birthplace Luxemburg

MOTHER
14. Maiden Name Elizabeth Mamer
15. Birthplace

16 (a) Informant Sr. M. Stan. Kostka
(b) Address 901 Aisquith Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 3/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem
Location Glen Arm

18 (a) Funeral director Geo. McSmith Son
(b) Address 811 N. Wolfe St

19 (a) MAY 2 1947 Registrar Wilkinson

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1947, at 11.15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from December 1944, to May 1 1947, and that I last saw h er alive on April 30 1947.

Immediate cause of death: Papillary Cancer
Due to: abdominal
Due to: Metastases
Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Dec 29 44

Major findings of operation: papillary Carcinoma drain

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. J. Kirby Jr. M.D.

Address 110 E. North Ave. Date signed 5/6/47

1287.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G51287, Registered No.

TYPE OR PRINT. Every item of information should be carefully supplied. Where information is not known, write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert St
(c) Hospital or institution: Mercy Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Balt.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1004 Cathedral St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Pate Bunton

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	Single

6 (b) Name of husband or wife ?
6 (c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.) Mar 3rd 1888

8. AGE: Years	Months	Days	If less than one day
59	1	27	..... hr. ..... min.

9. Birthplace Penn ? (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Daniel A. Bunton
13. Birthplace Penn.

MOTHER
14. Maiden Name Frances O'Dell
15. Birthplace Penn.

16 (a) Informant The Patient
(b) Address

17 (a) Removal (b) Date thereof 5/2/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bristol
Location Bristol Penn

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

(c) MAY 2 — 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1947, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 27 1947 to April 30 1947, and that I last saw him alive on April 30 1947.

Immediate cause of death	Duration (interval between onset and death)
Cardiac failure	
Due to Myocardial failure	6 mos.
Due to Coronary sclerosis	
Other Conditions Gen. Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: ?
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wilmarth Kimball, Jr. M. D.
Address Union Memorial Hosp. Date signed 4-30-47

X

G51288

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G51288 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 745 E. 37th St.
(c) Hospital or institution:
none 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 745 E. 37th St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Wolfkill

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife Henry E. Wolfkill
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1861

8. AGE: Years	Months	Days	If less than one day
85	10	16	hr. min.

9. Birthplace Chambersburg, Pa.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name George Jones
13. Birthplace Pa.

MOTHER
14. Maiden Name Mary Hockman
15. Birthplace Pa.

16 (a) Informant Mrs. Ruth Phipps
(b) Address 745 E. 37th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/4/47 (month) (day) (year)
(c) Cemetery or crematory Cedar Grove
Location Chambersburg, Pa.

18 (a) Funeral director John O. Mitchell & Sons Inc.
(b) Address 1900 Eutaw Place

MAY 7 1947 (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2, 1947 19 , at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 47 to 5-2 19 47 and that I last saw h alive on 5-1 19 47

Immediate cause of death Cardio-vascular-renal disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. L. Ewald Jr. M.D.

Address 3926 Greenmount Ave. Date signed 5/2/47

VS 150

×

G51289

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 157E

Registered No. G51289

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 9

2. USUAL RESIDENCE OF DECEASED:
(a) State Mich (b) County
(c) City or town Marquette (If outside city or town limits, write RURAL and give town)
(d) Street No. 207 Jackson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Beverly J. Lachapelle (Beverly J. LaChapelle)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, ~~married, widowed, or divorced~~

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-11-36

8. AGE: Years 10 | Months 11 | Days 20 | If less than one day hr. min.

9. Birthplace Michigan (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Jeffry Lachapelle
13. Birthplace Mich

MOTHER 14. Maiden Name Dora Beauchamp
15. Birthplace Mich

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 5/47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Marquette Mich

18 (a) Funeral director John O. Mitchell & Son
(b) Address 1900 Eutaw Place

19 (a) MAY 7 1947 (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-1-1947 at 9:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-27-1947 to 5-1-1947 and that I last saw her alive on 5-1-1947.

Immediate cause of death Congenital Heart Disease — Duration Life

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 4/29/47

Major findings of operation: Tuberculous stenosis

of autopsy: Tetralogy of Fallot

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry T. Bahnson M.D.
Address J.H.H. Date signed 5/5/47

VS 150

X

G51290

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 91a

Registered No. G51290

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1319 Madison ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1319 Madison ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie C. Butts

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 12. 1901

8. AGE: Years	Months	Days	If less than one day
45	5	18	hr. min.

9. Birthplace Eastville Virginia (Town, county and state)
10. Usual Occupation Home Wife
11. Industry or business

FATHER
12. Name James Church
13. Birthplace Eastville Virginia

MOTHER
14. Maiden Name Hattie Shocker
15. Birthplace Eastville Virginia

16 (a) Informant Mrs Mattie Howe
(b) Address 1289 Chapel st. Norfolk Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 6. 1947 (month) (day) (year)
(c) Cemetery or crematory Norfolk Virginia
Location Norfolk County

18 (a) Funeral director Joseph A. Lively
(b) Address 66 W. Bennett Bellsboro

19 MAY 2 - 1947 (Date rec'd by Registrar) (b) Filed by Registrar Williamsville Va

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1, 1947 at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/12/47 to 4/29/47, and that I last saw h alive on 4/29/47

Immediate cause of death	Duration
Sub Acute Bacterial Endocarditis	2 mo
Due to Local infection	
Due to Hemiplegia left side	
Other Conditions Pyelonephritis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. D. Parkhurst M. D.
Address 536 W. Cayuga Date signed 5/2/47

PRESS WITH PENCIL; WITH NON-FADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51291

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

§3a

Registered No. G51291

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Dennison St.
(c) Hospital or institution:
Crawford Retreat 1813
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1121 W. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles J. Dailey

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Catherine T. Dailey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28, 1864

8. AGE: Years 82 | Months 9 10 | Days 2 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Tinner - Self

11. Industry or business

FATHER
12. Name J. Dailey
13. Birthplace Ireland

MOTHER
14. Maiden Name Rose ?
15. Birthplace Ireland

16 (a) Informant Mr. Anthony J. Dailey
(b) Address 1121 W. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 5, 1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cemetery
Location Baltimore, Md.

18 (a) Funeral director Wallis L. Amoreau
(b) Address 4510 Liberty Heights Ave.

19 (a) Date rec'd by local reg. MAY 2 — 1947 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1947 at 8.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to April 30 1947. and that I last saw him alive on April 30 1947

Immediate cause of death	Duration
Uremia	
Cerebral apoplexy	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Wade M. D.
Address 2314 W. North Ave. Date signed

VS 150

G51292

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G51292

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2628 N. Charles St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Forbes

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-07-5906

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Earl R. Forbes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9 1897

8. AGE: Years	Months	Days	If less than one day
49	9	19	hr. min.

9. Birthplace Texas
(Town, county, and state)

10. Usual Occupation
11. Industry or business Stafford Hotel

FATHER
12. Name Joe Thier
13. Birthplace Hungary

MOTHER
14. Maiden Name Sadie Rich
15. Birthplace Texas

16 (a) Informant Michael Montecavallo
(b) Address 2400 Lauretta Ave.

17 (a) Burial (b) Date thereof 5/5/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cedar Hill
Location A. A. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 129 St. Paul St.

MAY 3 - 1947 (a) (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/28 1947, at 11:44 M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. F. Julian Jr. M.D.
Medical Examiner.
Date signed 4/29/47

G51293

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. G51293

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 200 N Calvert St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 200 N Calvert St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jessie J Carnes (Carnes)

3 (b) If veteran, name war NO

3 (c) Social Security Account No. XXX

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Divorced

6 (b) Name of husband or wife Blank

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 24 1892

8. AGE: Years 53 | Months 6 | Days 6 | If less than one day hr. min.

9. Birthplace Clark Co Va
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Charles H Symons
13. Birthplace Va

MOTHER
14. Maiden Name Emma J Meyer
15. Birthplace Va

16 (a) Informant Mrs Norma Morgan

(b) Address 0200 N Calvert St

17 (a) Burial (b) Date thereof 5/3/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory London Park

Location Balto. Md.

18 (a) Funeral director William Cook Inc

(b) Address 127 St Paul St.

19 MAY 3 - 1947 (b) Huntingtown Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3d 1947, at 1.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1946 to April 30 1947 and that I last saw her alive on April 26 1947.

	Duration
Immediate cause of death Carcinoma of Cervix	6 mos
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J M Callens M. D.
Address 5361 Frederick Ave Date signed 5/2/47

VS 150

FAILURE TO FILL IN ANY ITEM, WITH DATA AS ACCURATE AS KNOWN, MAY DELAY BURIAL. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

651294

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 651294

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene + Lombard
(c) Hospital or institution: University Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2878 Woodbrook ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha M Stauch

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife: Geo. Fred Stauch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 18th 1868

8. AGE: Years 78 | Months 6 | Days 13 | If less than one day hr. min.

9. Birthplace Washington D.C.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business At Home

FATHER
12. Name Frank Pumphrey
13. Birthplace Washington D.C.

MOTHER
14. Maiden Name (Unknown) Murphy
15. Birthplace Washington D.C.

16 (a) Informant George F. Stauch
(b) Address 1407 E. Main St

17 (a) Burial (b) Date thereof 5/5/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director Williams Cook Inc.
(b) Address 1217 St. Paul St.

MAY 3 - 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/1 1947, at 5:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-30 1947 to 5-1 1947, and that I last saw h[er] alive on 5-1 1947.

Immediate cause of death Diabetic Coma
Cerebral Thrombosis
Due to Arteriosclerotic Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ely Massenburg Jr. M. D.

Address University Hosp. Date signed 5-1-47

X

G51295

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G51295

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3727 Park Heights ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life time

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3727 Park Heights ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Emanuel Manko

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-10-7630

4. Sex male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Rosa Manko
6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) Oct 27 - 1874

8. AGE: Years	Months	Days	If less than one day
72 73	6	45	..... hr. ..... min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Clothing industry

FATHER
12. Name Joseph Manko
13. Birthplace Germany

MOTHER
14. Maiden Name Esther Blum
15. Birthplace Baltimore Md

16 (a) Informant Mrs. Rosa Manko
(b) Address 3727 Park Heights ave

17 (a) Burial (b) Date thereof May 4/1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore Hebrew Cem
Location Belair Road

18 (a) Funeral director Sol Levinson Bros
(b) Address 1124-26 W Mathews ave

19 MAY 3 - 1947 (b) Reg'd by (Signature) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 1947 at 2 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1947 to May 1 1947 and that I last saw h[illegible] alive on May 1 1947.

Immediate cause of death	Duration
Myocarditis	
Coronary Thrombosis	
Cerebral edema	
Due to	
Due to Arterio Sclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Kadin M. D.
Address 2306 Eastern Pl Date signed 5-2-47

X

G51296

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G51296

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1212 Hanover St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1212 Hanover St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Roby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Wm. N. Roby
6 (c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) Aug. 21, 1872

8. AGE: Years	Months	Days	If less than one day
74	8	10	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business at Home

FATHER
12. Name Henry Kontner
13. Birthplace Germany

MOTHER
14. Maiden Name Henrietta Braise
15. Birthplace Baltimore, Md.

16 (a) Informant William N. Roby - (Husband)
(b) Address 1212 Hanover St. Balto. 30 Md.

17 (a) Burial - (b) Date thereof May 5, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto, Md.

18 (a) Funeral director Geo. Clinch & Son
(b) Address 1400 E. Clinch St. Balto. 30 Md.

19 MAY 3 - 1947 (b) Timothy Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1, 1947 at 6:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/28 1947 to 5/1 1947 and that I last saw h.w. alive on 5/1 1947.

Immediate cause of death Coronary Thrombosis — Duration 3 days

Due to

Due to

Other Conditions Hypertensive cardio vascular disease — 2 y

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. Henry - Coroner M. D.
Address 1126 Hanover St. Date signed 5/7/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V S 150

G51297.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G51297.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 624 N.Monroe St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 624 N.Monroe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha I Eccleston

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Richard Eccleston
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept.28,1874

8. AGE: Years	Months	Days	If less than one day
72	7	2 3	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name George Deal
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Winchester
15. Birthplace Md.

16 (a) Informant Mrs.Naomi Berry
(b) Address 966 Albany Ave.Hartford Conn.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May5/47 (month) (day) (year)
(c) Cemetery or crematory Balto. Nat. Cem.
Location Balto. Md.

18 (a) Funeral director Phillips Henry & Sons
(b) Address 2024 Orleans St.

19 MAY 3- 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION 12.25

20. DATE OF DEATH May 1,1947 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mch 15 1947 to May 1 1947.
and that I last saw him alive on May 1 1947.

Immediate cause of death	Duration
Coronary occlusion	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis Frahm M. D.
Address 182 N. Paca St. Date signed 5/2/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G51298

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G51298

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2529 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles A Brittan

3 (b) If veteran, name war

3 (c) Social Security Account No. 557-01-6345

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of ~~husband or wife~~ Lillian M (Klein)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 28 1902

8. AGE: Years 44 | Months 7 | Days 3 | If less than one day hr. min.

9. Birthplace California (Town, county, and state)

10. Usual Occupation Freight Handler

11. Industry or business W. T. Cowan

FATHER
12. Name Clarence Brittan
13. Birthplace Montana

MOTHER
14. Maiden Name Nettie Nolan
15. Birthplace California

16 (a) Informant Lillian M. Brittan
(b) Address 2529 W. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 5 1947 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location 3201 Frederick Ave

18 (a) Funeral director Harry H Wetzler
(b) Address 4 Edmondson Ave

19 (d) Huntington Williams, M.D.

MAY 3 - 1947
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-1- 1947 at 4:20 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Subdural Hemorrhage

Due to Fracture of Skull

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4/22/47 at 5:30 P.M. 21/2
(b) Where did injury occur? W. T. Cowan Co. 1527 Cayard St
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Fell from Platform

23. Signature Emil L Vogt M.D.
Medical Examiner
Date signed 5-2-47

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

051299

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 051299

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1910 Perlman Place
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1910 Perlman Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Henry Bontemann Berstermann

3 (b) If veteran, name war Spanish | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Lena

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 20th 1870

8. AGE: Years	Months	Days	If less than one day
77	3	13	hr. min.

9. Birthplace Cleveland Ohio
(Town, county, and state)

10. Usual Occupation Sheet Metal Worker

11. Industry or business Retired

FATHER — 12. Name Frank Berstermann
13. Birthplace Germany

MOTHER — 14. Maiden Name Catherine Remmel
15. Birthplace Germany

16 (a) Informant Mrs. Lena Berstermann
(b) Address 1910 Perlman Place

17 (a) Burial (b) Date thereof 5-5th 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory W.S. National
Location Frederick Road

18 (a) Funeral director Leo S. Cook
(b) Address 1701-03 N. Patterson Park Ave

19 (a) Filed MAY 8 1947 (b) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-2nd 1947 at 1.50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-16- 1946 to 4-30- 1947 and that I last saw him alive on 4-30 1947.

Immediate cause of death	Duration
Chronic Myocarditis	13 mos
Due to Arteriosclerosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nelson C. Haug M. D.
Address 2117 Belair Rd Date signed 5-3-47

VS 150

X

G51300 BALTIMORE CITY HEALTH DEPARTMENT G51300

CERTIFICATE OF DEATH 170c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1109 Abbott Court
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1109 Abbott Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence J. Thompkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 5th - 1870

8. AGE: Years 76 | Months 4 | Days 28 | If less than one day ____ hr. ____ min.

9. Birthplace Caro., Michigan
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Joshua Thompkins
13. Birthplace Caro., Michigan

MOTHER
14. Maiden Name Unk
15. Birthplace "

16 (a) Informant Dora Thompkins
(b) Address 1109 Abbott Court

17 (a) Removal (b) Date thereof 5-3-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Caro Michigan

18 (a) Funeral director John J. Cordelly
(b) Address 711 Eastern Ave & Huntington Williamsport, Md

19 (a) [illegible] by registrar) MAY 3 1947
Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2, 1947, at 3 30 P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary edema
due to coronary artery disease

Due to

Other Conditions Generalized arteriosclerosis, hydronephrosis, right; fracture, simple, left tibia and fibula
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury 4/30/47 at 2 30 A. M. 2615
(b) Where did injury occur? Eastern Ave. & Ponca St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Motorcycle and Bus collided

23. Signature Earl Pyle M.D.
Medical Examiner.
Date signed 5/3/47

X

Correct age in especially important. Physicians: please write the causes of death clearly and legibly.

C51301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C51301

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2021 BRADDISH AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2021 Braddish Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** ENFROZINA RYBIKOWSKY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife KASPER.
(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 6. 1888

8. AGE: Years 58 | Months 5 9 | Days 25 | If less than one day ..... hr. ..... min.

9. Birthplace LITHUANIA
(Town, county, and state)

10. Usual Occupation RETIRED

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace /

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mary Godzik
(b) Address 100 N Patapsco Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 4-47
(month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Charles H. Faehnrich
(b) Address 703 McHenry St.

19 MAY 3 - 1947 Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1st 1947, at 8:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to 5-1-47 19, and that I last saw her alive on 5-1-47. 19

Immediate cause of death	Duration
Terminal Lobular Pneumonia, Int. Coronary Thrombosis	6-10 days
Due to Myocardial failure, Hypertension & Arteriosclerosis	Years
Due to Pulmonary edema.	3-4 days
Other Conditions Obesity.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. E. Knight
Address 642 Wash. Blvd Date signed 5-3-47 M D

VS 150

X

51302

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G51302 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2075 Rockrose avenue
(c) Hospital or institution: Ardleigh Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 617 E. 33rd street (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME FREDERICK J. CRANE

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Lillie Persinger Crane
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): April 29, 1859
8. AGE: Years 88 Months - Days 3 If less than one day hr. min.
9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: Retired Hatter
11. Industry or business

FATHER
12. Name: Charles Crane
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Katherine Nolan
15. Birthplace: Ireland

16 (a) Informant: Mrs. Lillie Persinger Crane
(b) Address: 617 E. 33rd street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/5/47 (month) (day) (year)
(c) Cemetery or crematory: Cathedral
Location

18 (a) Funeral director: Chas. J. Gruner Son Inc
(b) Address: 116 W. Mt. Royal Ave.

19 MAY 3 - 1947 (Date rec'd by registrar) Washington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1947 to May 2 1947.
And that I last saw h[illegible] alive on May 1 1947.

Immediate cause of death: Cong. Heart Failure — Duration
Due to: Arteriosclerotic C.V. Dis.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?: (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Edward E. Hammond, M.D.
Address: 9-0178 Falls Rd Date signed 5/7/47

Every item of information should be carefully supplied. Type or write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

VS 150

G51303

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 48a

G51303 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Charles
(c) City or town Hughesville (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Cathleen Robinson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Morris Robinson

6 (c) If alive, give age 27 years

7. Birth date of deceased (mo., day, yr.) 6-7-20

8. AGE: Years 26 | Months 10 | Days 25 | If less than one day ... hr. ... min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joseph Johnson
13. Birthplace Md

MOTHER 14. Maiden Name Sarah Jones
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 5/5/47 (month) (day) (year)
(c) Cemetery or crematory St Mary Cemetery
Location Baltimore Md

18 (a) Funeral director Edward McGrath
(b) Address Baltimore Md

MAY 3 - 1947 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 1947, at 7:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 30 1946, to May 2 1947, and that I last saw her alive on May 2 1947.

	Duration
Immediate cause of death: CACHEXIA	
Due to: CARCINOMA cervix	
Due to:	
Other Conditions: Ascites	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Josephine E Renshaw M.D.
Address Johns Hopkins Hosp Date signed 5/3/47

G51304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

Registered No. G51304

Please write the causes of death clearly and legibly. Physicians, please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1607 E. 30th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME J Richard Stevens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	Married

6 (b) Name of husband or wife Stella J. Stevens
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29, 1901

8. AGE: Years	Months	Days	If less than one day
45	11	3 4	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Marine Supt.
11. Industry or business

FATHER
12. Name Albert Stevens
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mamie Boone
15. Birthplace Baltimore

16 (a) Informant Mrs. Stella J. Stevens
(b) Address 1607 E. 30th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/5/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director W. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAY 3 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-2- 19 47 at 10 25 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Drowning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 25/5
(a) Date of injury 5-1-47 at Between 4 P.M. & 6 P.M.
(b) Where did injury occur? Harbor: Docks, Locust Pt.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? Yes
(d) Means of injury Found drowned.

23. Signature George L. Merrill M.D. Medical Examiner.
Date signed 5-2-47

G51305

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G51305

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 216 S. Augusta Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 216 S. Augusta Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PEARL FRANCES CLARK

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Orval W. Clark
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 15, 1897

8. AGE: Years	Months	Days	If less than one day
49	4	17	hr. min.

9. Birthplace Oxford, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Alexander Harris
13. Birthplace Md.

MOTHER
14. Maiden Name Mary F. Rumbold
15. Birthplace Md.

16 (a) Informant Mr. Orval W. Clark
(b) Address 216 S. Augusta Ave.

17 (a) Burial (b) Date thereof 5/5/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAY 3 - 1947 (b) Huntingtor Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH May 2, 1947, at 2:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 17 1947, to May 2 1947, and that I last saw her alive on May 1 1947.

Immediate cause of death	Duration
Coronary Thrombosis	3 mos.
Due to	
Due to	
Other Conditions Arteriosclerosis & Hypertension. (Include pregnancy within 3 months of death)	3 mos.

Date of operation None
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —

23. Signature D. Walter Spurrier
Address 3603 Edmondson Ave Date signed 5/3/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Certificates should be carefully supplied.

VS 150

G51306
514282

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

122B

G51306
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Washington D. C.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1018 B. St. N. W. Wash
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Leer Reer.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-7-47

8. AGE: Years	Months	Days	If less than one day
	2	26	hr. min.

9. Birthplace Washington D. C. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Lelande Reer.
13. Birthplace Washington D.C

MOTHER
14. Maiden Name Nora Ree.
15. Birthplace N. C.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cemetery
Location

18 (a) Funeral director J. Wm. Lee Sons Co
(b) Address 340 - 4½ St N E D C.

19 (a) MAY 4 1947 (b) Registrar
(Date received by Registrar)

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH May - 2 1947, at 8.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from April - 27 1947 to May - 2 1947, and that I last saw him alive on May 2 1947.

Immediate cause of death	Duration
Respiratory failure	6 hr.
Due to Aspiration	
Due to Post-operation multiple ileostomy	5 days.
Other Conditions	over

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert J. Sheldon
Address Johns Hopkins Hosp. Date signed 5/3/47 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51307

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G51307 / 46 E

Registered No. G51307

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Lombard St.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 8110 Bullneck Rd. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Susan Becker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Charles

6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) DEC. 2, 1888

8. AGE: Years 58 | Months 5 | Days -1 | If less than one day ....hr. ....min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation H.W.

11. Industry or business

FATHER
12. Name Daniel Bayley
13. Birthplace PA

MOTHER
14. Maiden Name JEANETTE CRUTHERS
15. Birthplace PENN.

16 (a) Informant Husband
(b) Address Same

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAY 7 1947 (month) (day) (year)
(c) Cemetery or crematory CEMETERY
Location HAZELTON PA.

18 (a) Funeral director ROLAND L. FISHER
(b) Address 2112 DUNDALK AVE.

19 (a) ....(b) Huntington Williams, Mgr. (Date rec'd by registrar)

MAY 4 S-15 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-3 1947, at 12:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-19 1947 to 5-3 1947 and that I last saw her alive on 5-3 1947.

Immediate cause of death Bronchial Pneumonia — Duration

Due to DIFFUSE Peritonitis with Toxemia

Due to Adenocarcinoma of Caecum.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 4-19-47

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ....at ....M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Brockman M. D.
Address Univ. Hosp. Date signed 5-3-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51308

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G51308 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2024 W. Saratoga St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town? Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2024 W Saratoga St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John C Buettner

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-07-1713

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Marguerite Conway

6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) June 17 1903

8. AGE: Years 43 | Months 10 | Days 15 | If less than one day hr. min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation Trade Clerk

11. Industry or business Trading Stamps

FATHER
12. Name John Buettner
13. Birthplace Balto

MOTHER
14. Maiden Name Margaret Murray
15. Birthplace Balto Md

16 (a) Informant Mrs. Margt Buettner
(b) Address 2024 W. Saratoga St

17 (a) Burial (b) Date thereof May 6 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Rita Wadsfield
(b) Address 900 E Biddle St

19 (a) MAY 4 1947 (b) Huntington Williams MD
(Date received by registrar)

VS 150

Dr Edw Leach 15 E. Eager St

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2, 1947, at 105 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/7 1944 to 5/2 1947, and that I last saw him alive on 9/21 1946

Immediate cause of death: Coronary thrombosis — Duration: Acute

Due to: Arteriosclerotic heart disease — 4 yrs.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. Edward Leach M. D.
Address 14 E Eager St. Date signed 5/3/47

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51309 B#305 1308

BALTIMORE CITY HEALTH DEPARTMENT X
CERTIFICATE OF DEATH / 159

G51309
Registered No.

Please write plainly in ink. Information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene St.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 ds.
(e) Length of stay in Baltimore (yrs., mos., or days) 8 ds

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Ellicott City
(If outside city or town limits, write RURAL and give town)
(d) Street No. Main St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Miller

3 (b) If veteran, name war: None
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/25/47

8. AGE: Years 0 | Months 0 | Days 8 | If less than one day hr. min.

9. Birthplace University Hospital (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Rev. C. H. Miller
13. Birthplace Virginia

MOTHER
14. Maiden Name Maddie Imay
15. Birthplace Kentucky

16 (a) Informant Rev. C. H. Miller
(b) Address Ellicott City Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 4, 1947 (month) (day) (year)
(c) Cemetery or crematory St. Johns Cem.
Location Ellicott City Md.

18 (a) Funeral director Easton Sons
(b) Address Ellicott City Md.

19 (a) (Date received by registrar) (b) Registrar Huntington Williams

MAY 4 - 1947
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3, 1947, at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 26 1947 to May 3 1947 and that I last saw him alive on May 3, 1947.

Immediate cause of death Anoxia — Duration

Due to Atelectasis

Due to Aspiration of Vomitus

Other Conditions Prematurity

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address University Hospital Date signed 5-3-47

X

G51310

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G51310 Registered No.

1. PLACE OF DEATH: DOA.
(a) Baltimore City, Maryland
(b) Street address 2648 Boone St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 H
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2648 Boone St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Willie Mae Allen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Married

6 (b) Name of husband or wife Willie V.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 21, 1899

8. AGE: Years	Months	Days	If less than one day
47	5	10	hr. min.

9. Birthplace Greenville, S. C. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Henderson
13. Birthplace Greenville, S.C.

MOTHER
14. Maiden Name Ella Meekins
15. Birthplace S. C.

16 (a) Informant Mrs. Willie V. Allen
(b) Address 2648 Boone St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-4-1947 (month) (day) (year)
(c) Cemetery or crematory Lorbeter Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George H. Hall
(b) Address 1631 Druid Hill Ave

19 (a) Huntington Williams, M.D. (Date rec'd by registrar) Registrar

MAY 5 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/1 1947, at 5:55 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Hypertension Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature G. L. Schumacher M.D. Medical Examiner.
Date signed 5/5/47

Correct age is supremely important. Physicians: please write the causes of death clearly and legibly.

A: 1651 G51311

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G51311 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1312 Loudon Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1312 Loudon Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If so, name country

3 (a) FULL NAME Sidron J Gnagey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Mary A

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 16 1870

8. AGE: Years 77 | Months 1 | Days 17 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Jacob J. Gnagey
13. Birthplace Md

MOTHER
14. Maiden Name Not known
15. Birthplace "

16 (a) Informant Harold S Gnagey
(b) Address 1312 Loudon Ave

17 (a) Burial (b) Date thereof 5-8-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Frankville Md

18 (a) Funeral director Geo. A. Tayler
(b) Address Fulton Geo. Tayler

19 (a) MAY 9 1947 (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 1947, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 5/3 1947.
and that I last saw him alive on 5/2 1947

Immediate cause of death Coronary occlusion. — Duration Stat.

Due to Arteriosclerosis — Injury No.

Due to

Other Conditions Chr. Valvular Heart — "

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 2020 H. Clarks Date signed 5/4/47

VS 150

CREATE WHITE SPACE, WITH UNFADING INK. Every item of information should be carefully supplied. Age, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51312

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G51312

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 259 Robert St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 259 Robert St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa Ella Ross

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: Years 86 | Months | Days | If less than one day hr. min.

9. Birthplace Essex Co. Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Croxton
13. Birthplace Va

MOTHER 14. Maiden Name Judy Baylor
15. Birthplace Va

16 (a) Informant Leila Stewart
(b) Address 259 Robert St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-6-47 (month) (day) (year)
(c) Cemetery or crematory Shiloh
Location Middlesex Co Va

18 (a) Funeral director James A Hayes
(b) Address 1142 Hotel St Huntington W. Va.

19 (a) 5-6-1947 (Date rec'd by registrar) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/4 47 7A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/10 47 to 5/4 47, and that I last saw h alive on 5/3 1947.

Immediate cause of death: Chr. nephritis
Uremia — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ben Rhett M. D.
Address 2134 Date signed 5/6/47

VS 150

Every item of information should be carefully supplied. The cause is especially important. Physicians: please write the causes of death clearly and legibly.

JI — 101632 G51313

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 195E

G51313 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 1
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 820 Boston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Gasporowicz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
66 ?	?	?	hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Stefan Gasporowicz
13. Birthplace Austria

MOTHER 14. Maiden Name Ulia ? Shromek
15. Birthplace Austria

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-6-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Frank Grach Son
(b) Address 900 N Chester St

19 (a) 1947 (b) Registered by registrar Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1, 1947, at 4.25PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 30 1946 to May 1 1947 and that I last saw h[im] alive on May 1, 1947

Immediate cause of death: Bronchopneumonia — Duration: 7 days

Due to:

Due to: Osteomyelitis Spleen removed, Hepatic abscess. Abd. tuberculosis. Intertrochanteric fracture, right femur.

Other Conditions (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 3/2
(a) Accident, suicide, or homicide accident ?
(b) Date of occurrence 4/6/47 at ?? M
(c) Where did injury occur? Baltimore, Md. (City or town) (County) (State)
836 E. Biddle
(d) Did injury occur about home, on farm, industrial place, in public place? public street While at work? —
(Specify type of place)
(e) Means of injury ???

23. Signature A. Libby
Address Balt. City Hospitals Date signed 5/7/47

Huntington Williams, M.D. Patient could not speak English and gave an account of injury. X
P. J. Zebrowski

G51314 BALTIMORE CITY HEALTH DEPARTMENT G51314

CERTIFICATE OF DEATH 477

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3700 N. Charles St.
(c) Hospital or institution: Northway Apts. 17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3700 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edwin T. Foreman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: M.May Johnsen Foreman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 16, 1880

8. AGE: Years 66 | Months 5 | Days 18 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Edwin F. Foreman
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Theodore F. Foreman
(b) Address 3700 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 5/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Harry A. Tuttle
(b) Address 4101 Edmondson Ave.

19 (a) (Date received by registrar) Washington Williams M.D. Registrar

MAY 4 - 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2/47 19 , at 11:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1937 to 5/2 1947. and that I last saw him alive on 5/2 1947

Immediate cause of death Cardiovascular Renal

Duration: P.

Due to

Due to

Other Conditions Arteriosclerotic Heart Disease

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jack R. Morgan M.D.

Address 18 E. Eagle St. Date signed 5/3/47

X

G51315

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

G51315 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2727 West North Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 Mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2727 W. North Ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN H. HUGHART

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO.....	232-05-4486

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Nancy A.
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) May 26, 1880

8. AGE: Years	Months	Days	If less than one day
66	11	7	....hr. ....min.

9. Birthplace Walton West Va. (Town, county, and state)
10. Usual Occupation Minner Coal
11. Industry or business

FATHER
12. Name James Hughart
13. Birthplace West Va.

MOTHER
14. Maiden Name Martha Rodgers
15. Birthplace West Va.

16 (a) Informant Mrs. Nancy A. Hughart
(b) Address 2727 West North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 May 47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore Maryland

18 (a) Funeral director F.B.WIPPERT & SON
(b) Address 1300 Eutaw Place...17

19 (a) MAY 4 1947 (Date received by registrar) (b) [illegible] Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2/1947 19.. at 5:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from [illegible] 19 47 to May 2 1947, and that I last saw him alive on May 2 1947

Immediate cause of death	Duration
Fuels Muscular accident c Coma	
Due to Acute Nephritis Diabetes	
Due to Diabetic coma.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature W. O. Needle
Address 314 W. North Ave Date signed 5/4/47

X

G51316

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 463

G51316
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1520 Battery ave
(c) Hospital or institution:
4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1520 Battery ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret J. Mannion

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Married

6 (b) Name of husband or wife William J Mannion 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/18/92

8. AGE: Years	Months	Days	If less than one day
54		18 29	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER
12. Name John McHale
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine McHale
15. Birthplace Ireland

16 (a) Informant Mrs M J. Mannion
(b) Address 1520 Battery Ave

17 (a) Interment (b) Date thereof 5/5/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Bel Air Rd & Taberts Lane

18 (a) Funeral director J. J. Gahan
(b) Address 1217 Light St.

19 (a) MAY 4 - 1947 (b) Huntington Williams, Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1947, at 12 23 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1946 to 4/29 1947 and that I last saw her alive on 4/29 1947

Immediate cause of death Accumulation of Stomach

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E J Stevenson M. D.
Address 107 E. West St. Date signed

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

FLECK

G51317

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G51317

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3516 CATON AVE
(c) Hospital or institution: NO
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore — (If outside city or town limits, write RURAL and give town)
(d) Street No. 3516 Caton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY FLECK

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June - 1 - 1870

8. AGE: Years	Months	Days	If less than one day
76 77	11	1	hr. min.

9. Birthplace GERMANY (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Fleck
13. Birthplace GERMANY

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace

16 (a) Informant Mrs. MATHILDA VOTTA
(b) Address 3516 Caton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-5-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Fayette and Edmondson Ave

18 (a) Funeral director Thos. J. Kenny Inc
(b) Address Gilmor & Hollins Sts

19 (a) 5 - 1947 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/2/47 19 at 5 P M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 1947 to 5/1/47 19; and that I last saw h alive on 5/1/47 19

Immediate cause of death: Acute Myocarditis — Duration: 2 days

Due to: Arteriosclerosis — Duration: indefinite

Due to: Nephritis — Duration: "

Other Conditions: Enlarged Prostate — Duration: "

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. F. Doran
Address 402 Edmondson Ave Date signed 5/3/47

X

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51318 BC# F76975

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G51318

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Harbor Mansion Ct (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY ELIZABETH LITTLE
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15 1942

8. AGE: Years	Months	Days	If less than one day
3	11	19	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Robert N Little
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Elizabeth MacBride
15. Birthplace Ireland

16 (a) Informant Robert Little
(b) Address N Luncheon Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/7/47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Baltimore Co Md

18 (a) Funeral director Gilbert & Joyce
(b) Address 217 E Lanvale St

19. MAY 5 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 4 1947, at 2.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from MAR. 25 1947 to MAY 4 1947, and that I last saw her alive on MAY 4 1947.

Immediate cause of death	Duration
Tuberculous Meningitis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Morris D. Michael M. D.
Address Sinai Hospital Date signed May 7 1947

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V S 150

G51319

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G51319

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Sts
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1910 Mc Elderry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie M. Hardtke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: ~~Male~~ Female

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of husband ~~Ernest~~ Ernest T. Hardtke

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26th 1887

8. AGE: Years 54 | Months 5 | Days 7 | If less than one day ____ hr. ____ min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name John G. Lutsch
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Eckhart
15. Birthplace Germany

16 (a) Informant Ernest T. Hardtke
(b) Address 1910 Mc Elderry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/6/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ St. Matthews
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (Date rec'd by registrar) MAY 5 - 1947 Huntington-Williams, Mgr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/3/1947 at 3:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/1/1947 to 5/3/1947 and that I last saw her alive on 5/3/1947.

Immediate cause of death	Duration
Myocardial failure	
Due to Myocardial insufficiency	1 day
Due to Cerebral hemorrhage	2 days
Other Conditions Diabetes mellitus (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. E. Gonzalez
Address Maryland G. Hosp. Date signed 5/2/47

VS 150

93E

G51320

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 94a

Registered No. G51320

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert and 33rd Sts
(c) Hospital or institution: Union Memorial Hospital 326
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore - 22 (If outside city or town limits, write RURAL and give town)
(d) Street No. 6517 Cleveland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDGAR HAROLD HARVEY

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-09-2922

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary Ellen Harvey
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) 10-15-1897

8. AGE: Years	Months	Days	If less than one day
49	6	18	hr. min.

9. Birthplace Massachusetts (Town, county, and state)
10. Usual Occupation Typesetter
11. Industry or business Bethlehem Steel

FATHER
12. Name George A. Harvey
13. Birthplace Massachusetts

MOTHER
14. Maiden Name Estella Blauvelt
15. Birthplace Nova Scotia

16 (a) Informant Same
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/6/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Moreland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 217 St. Paul St.

19 (a) MAY 5 - 1947 (Death rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 1947 at 9 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1947 to May 3 1947, and that I last saw h live on May 3 1947.

Immediate cause of death	Duration
Cardio-Vascular Accident	4 days ?
Due to Mural Thrombi	
Due to Myocardial infarction	3 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy Confirm

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. D.
Address Date signed 5/2/47

Hosp X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51321

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G51321

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 227 W. Read St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) 6 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 227 W. Read St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Frances Poole

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W	Widowed

6 (b) Name of husband or wife George Poole
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 17, 1861

8. AGE: Years	Months	Days	If less than one day
86	3	17	hr. min.

9. Birthplace Phila., Pa.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frank Smart
13. Birthplace Pa.

MOTHER
14. Maiden Name Sarah A Cline
15. Birthplace Balto. Md.

16 (a) Informant Walter Poole
(b) Address Woodstock, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 6, 1947 (month) (day) (year)
(c) Cemetery or crematory Poplar Springs Cem.
Location Poplar Springs, Md.

18 (a) Funeral director C. Harry Weis
(b) Address Sykesville Md

(a) Date received MAY 8 1947 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4, 1947 at 6:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 29, 1947 to May 4, 1947 and that I last saw him alive on May 3, 1947

Immediate cause of death	Duration
Cerebral Thrombosis	
Due to Arteriosclerosis, Cardio-Vascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Sigmund Gedberg

Address 622 S. Broadway Date signed 5/14/47

X

G51322

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G51322

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 839 Leadenhall
(c) Hospital or institution: 7W
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 839 Leadenhall (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Goldie Bell

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Noah Bell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22 1885

8. AGE: Years 61 | Months 11 | Days 20 | If less than one day hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation at Home

11. Industry or business

FATHER
12. Name Isaiah Wesley
13. Birthplace md

MOTHER
14. Maiden Name Masculen Darlinfield
15. Birthplace md

16 (a) Informant Sarah Bell Hollins
(b) Address 841 Leadenhall St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-5-47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director James A Sayer
(b) Address 142 Hustead St

19 (a) MAY 5 1947 (b) [illegible] Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 1947, at 3:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 19th, to May 2 1947, and that I last saw her alive on Apr 7 1947.

Immediate cause of death	Duration
Hypertension; Cardio-renal disease	10 Yrs
Due to	
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H L Moseley Jr
Address 2014 Madison Ave Date signed 5/8/47

H L Moseley Jr

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51323

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G51323

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1618 Hanover St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 43
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1618 Hanover St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Louis Lancaster

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-05-6135

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife (Use Maiden Name) Catherine L. Lancaster 6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 9, 1871

8. AGE: Years 75 | Months 5 | Days 6 | If less than one day 24 hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business —

FATHER
12. Name Joseph Lancaster
13. Birthplace Md.

MOTHER
14. Maiden Name Louisa Schabels
15. Birthplace Md.

16 (a) Informant Geo. L. Lancaster, Son
(b) Address 1618 Hanover St Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/6/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto. Co., Md.

18 (a) Funeral director Boyd A. Evans
(b) Address 1405 S. Charles St Balto. Md.

19 (a) MAY 5 1947 (b) Huntington for Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3, 1947 at 5:00 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/3 19 47 to 5/3 19 47 and that I last saw him alive on 5/2 19 47

Immediate cause of death Carcinoma of Pancreas

Carcinoma of Liver

Due to

Due to

Other Conditions Patient confined to bed 1 mos. prior to hospitalization

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Isaac Miller M.D. M. D.

Address 224 N. Charles St Date signed 5/7/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

651324

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G51324

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 W University Pkwy
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 100 W. University Pkwy. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annabelle Merryman Lucas

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	widow

6 (b) Name of husband or wife Harry P. Lucas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan ? 1851

8. AGE: Years	Months	Days	If less than one day
96 95	4		hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER	12. Name Joseph L Merryman
	13. Birthplace Balto Co Md
MOTHER	14. Maiden Name Martha Gray
	15. Birthplace Md

16 (a) Informant H. Percy Lucas
(b) Address Brooklandville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 5 1947 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Balto Md

18 (a) Funeral director Henry W. Jenkins Sons Co
(b) Address McCulloh & Orchard Sts

19 (a) MAY 5 1947 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3rd 1947, at 7 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1st 1947, to May 3rd 1947, and that I last saw her alive on May 3rd 1947.

Immediate cause of death	Duration
Myocardial Insufficiency	1 day
Pulmonary Edema	
Due to Cirrhosis	
Due to —	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. A. Collard M. D.
Address 1300 N. Calvert St Date signed May 5 1947

Well filled X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51325 BROWN ✓ G51325

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Dist.
(b) Street address 516 N. Pulaski St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 516 N. Pulaski St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Brown

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Wade Hampton Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years	Months	Days	If less than one day
78			hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Home wife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant
(b) Address

17 (a) Removal (b) Date thereof 5/6/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mount Olive Church cemetery
Location Baltimore Co.

18 (a) Funeral director Ball B. Preston Funeral Home
(b) Address 493 E-25th St

19 MAY 5 - 1947 (b) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/4 19 47 at 2:25 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Nature of injury

23. Signature Ralph Truitt M.D.
Medical Examiner.
Date signed 5/7/47

G51326

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G51326

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3736 Hickory Ave.
(c) Hospital or institution: 12

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3736 Hickory Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosie Hoffnagle.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Joseph K. Hoffnagle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1876

8. AGE: Years 70 | Months 9 | Days 29 | If less than one day hr. min.

9. Birthplace Maryland.
(Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name Unknown.
13. Birthplace Unknown.

MOTHER
14. Maiden Name Unknown.
15. Birthplace Unknown.

16 (a) Informant Francis J. Hoffnagle.
(b) Address 1316 Union Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 5/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location

18 (a) Funeral director Chenoweth & Donovan.
(b) Address 3615 17 Chestnut Ave.

19 MAY 5 1947 [illegible]

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 17 1947, to May 2 1947, and that I last saw h.e alive on May 1 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	4-5 days
Due to Hypertensive CVD	
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edw. J. Hayman M. D.
Address 4037 Falls Rd. Date signed 5/4/47

X

Every item of information should be carefully supplied. Use ink or typewriter, and write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G51327

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50 ✓

Registered No. G51327

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1633 N. Durham St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1633 N. Durham St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Marie B. Butler

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	D

6 (b) Name of husband or wife Charles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24, 1908

8. AGE: Years	Months	Days	If less than one day
38	10	9	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation candy paker
11. Industry or business Voniel Drayer

FATHER
12. Name James F. Skarda
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Hanzlik
15. Birthplace Baltimore

16 (a) Informant Lillian B. Matzen
(b) Address 1633 Durham St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/5/47 (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Hoerners Lane

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 MAY 5 — 1947 (Date rec'd by Local Registrar) Huntington Williams, M.D. (Signature of Local Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 1947, at 9.20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1947, to May 2 1947, and that I last saw her alive on May 2 1947

Immediate cause of death	Duration
Carcinoma Lungs	
Due to	
Due to	
Other Conditions Metastaminits Lungs (Include pregnancy within 3 months of death)	

Date of operation Jan 1947.
Major findings of operation: Carcinoma Breast
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jacob Fisher M. D.
Address 1823 N. Wash St. Date signed 5/6/47

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51328

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G51328

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2806 W. Lanvale St.
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2806 W. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME William A. Redner

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NO

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Edith R. Redner

6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1872

8. AGE: Years 74 | Months 6 | Days 23 | If less than one day: hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Maximilian Redner
13. Birthplace Germany

MOTHER
14. Maiden Name Charolett Dominic
15. Birthplace Germany

16 (a) Informant: Alan Redner
(b) Address 2806 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/6/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

19 (a) MAY 5 - 1947 (Date rec'd by registrar) Huntington Williams, M.D. Address 1201 Eyler Home St Date signed 5-4-47

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3, 1947, at 9:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1938, to May 3 1947, and that I last saw him alive on May 3 1947.

Immediate cause of death: Cerebral Hemorrhage — Duration 2 days

Due to: Arteriosclerosis — ? years

Due to:

Other Conditions: Chronic Bronchitis & Emphysema — ? years
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: Not Done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jean Eckman M. D.

VS 150

X

G51329

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G51329

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4203 Springdale Av
(c) Hospital or institution: Mrs Lewis' Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4207 Springdale (If rural give location)
(e) Citizen of foreign country? (Yes or No) NO
If yes, name country

3 (a) FULL NAME Leonora Robinson

3 (b) If veteran, name war	3 (c) Social Security Account No.
NONE	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec. 28, 1870

8. AGE: Years	Months	Days	If less than one day
76	4	4	hr. min.

9. Birthplace Longhill-Marley Station-A.A.Co-Md
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Dr. Chas. B. Robinson
13. Birthplace Q. A. Co. - Md.

MOTHER
14. Maiden Name Patience Hardup
15. Birthplace A. A. Co. - Md.

16 (a) Informant Mrs. Mary H. Foreman
(b) Address Charles Apts-3333 N. Charles St-City

17 (a) Burial (b) Date thereof 5-6-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn - A.A. Co. - Md.

18 (a) Funeral director Stewart & Morris Co.
(b) 108 W. Saratoga St.

19 (a) MAY 5 - 1947 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1947 at 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946, to May 24 1947, and that I last saw her alive on May 1 1947.

Immediate cause of death	Duration
Carcinomatosis	3 ?
Due to Carcinoma of the Sigmoid	2 yrs +
Due to	
Other Conditions Hypertensive Cardiovascular disease, Cerebral Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation May 1945
Major findings of operation: Carcinoma of Sigmoid
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Martin L. Sengewald M.D.
Address 1109 St Paul St Date signed 5-7-47

VS 150

X

G51330

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G51330

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2237 Banlay St.
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County Baltolitty
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2237 Banlay St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Layton Monroe Shields

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Della C. Shields

6 (c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): Jan 5 1877

8. AGE: Years 70 | Months 3 | Days 27 | If less than one day: hr. min.

9. Birthplace: Cumberland Md.
(Town, county, and state)

10. Usual Occupation: none

11. Industry or business: none

FATHER
12. Name: — ? —
13. Birthplace: Cumberland Md.

MOTHER
14. Maiden Name: Laura Fisher
15. Birthplace: Cumberland Md.

16 (a) Informant: Mrs Della C. Shields (wife)
(b) Address: 2237 Banlay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: May 6-47 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore Md

18 (a) Funeral director: Stewart Morrill Co.
(b) Address: 1080 W North Ave.

19 (c) MAY 5 - 1947 Registered by registrar: Huntingtown Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 1 1947, at 9:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 28 1947, to May 1 1947, and that I last saw h[illegible] alive on May 1 1947.

Immediate cause of death	Duration
Coronary Occlusion	
Due to Bronchopneumonia	3 days
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Carl H. Beuse, M.D.
M. D.
Address: 5111 York Rd Date: May 7 1947

VS 150

G51331

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G51331

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3728 Eastern ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3728 Eastern ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Metzger

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 2 1875

8. AGE: Years 72 | Months 3 | Days 29 | If less than one day hr. min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation Cooper

11. Industry or business

FATHER 12. Name George Metzger Sr

13. Birthplace Germany

MOTHER 14. Maiden Name Anna Schaden

15. Birthplace Germany

16 (a) Informant Miss Friederike Metzger

(b) Address 3728 Eastern ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 5 47 (month) (day) (year)

(c) Cemetery or crematory Mt Carmel Cem

Location City

18 (a) Funeral director Ullrich Funeral Home

(b) Address 2008 Orleans St

19 (a) (b) Huntington Williams, M.D. Registrar

MAY 5 1947

VS 150

MEDICAL CERTIFICATION 40

20. DATE OF DEATH May 1 1947, at 1 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 27 1946 to May 1 1947 and that I last saw h.[illegible] alive on April 30 1947

Immediate cause of death — Duration

Acute Cardiac Failure

Due to Coronary Occlusion

Due to Coronary Thrombosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. A. Flannigan M.D.

Address 3503 Fait ave Date signed 5-1-47

G51332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G51332

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 239 N. Lakewood Dist
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 239 N. Lakewood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie K. Beste

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 12 1869

8. AGE: Years 77 | Months 8 | Days 20 | If less than one day ... hr. ... min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation
11. Industry or business At home

FATHER
12. Name Herman C Beste Sr
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Lande
15. Birthplace Germany

16 (a) Informant Herman C Beste Jr.
(b) Address 239 N Lakewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 6 (month) (day) (year)
(c) Cemetery or crematory Cremation
Location London Park.

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2001 Pennsylvania Ave, Balto

19 MAY 5 - 1947 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 1947 at 4:00 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic CV disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature ... M.D.
Medical Examiner.
Date signed 5/2/47

G51333 BC#G-77171

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160c

Registered No. G51333

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address E. Monument St.
(c) Hospital or institution: Sinai Hosp. 7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1430 E. Madison St #5
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby "A" Wright

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 30 1947

8. AGE: Years NB | Months | Days | If less than one day hrs min.

9. Birthplace BALTO., MD (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William Wright
13. Birthplace Va.

MOTHER 14. Maiden Name Margaret Hatcher
15. Birthplace Balto. Md.

16 (a) Informant Hospital Records.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/5/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director C. F. Schimmel
(b) Address 2601 E. Madison St.

19 MAY 5 - 1947 (b) (Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 30, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19, to 19, and that I last saw h alive on 19.

Immediate cause of death Prematurity

Due to Premature rupture of membranes

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Rubin, M.D.
Address Sinai Hospital Date signed 6/3/47

X

Please write plainly, with unfading ink. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51334 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G51334

CERTIFICATE OF DEATH

W# A-77172 160c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address E. Monument St.
(c) Hospital or institution: Sinai Hosp. T
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTo. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1730 E. Madison St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl "B" Wright

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 30 1947

8. AGE: Years NB | Months | Days | If less than one day 2 hr. 5 min.

9. Birthplace BALTo. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William Wright
13. Birthplace Va.

MOTHER 14. Maiden Name Margrit Kupfer
15. Birthplace Balto. Md.

16 (a) Informant Hospital Records.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/5/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road
18 (a) Funeral director C. F. Schimmel
(b) Address 2601 E. Madison, St.

(a) (b)
(Date rec'd) (Registrar) Registrar

MAY 5 - 1947

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MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 30, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19

Immediate cause of death Prematurity
Due to premature rupture of membranes
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Kupfer
Address Sinai Hospital Date signed 5/5/47 M.D.

THESE WORDS PRINTED, WITH ONE LETTER IN EACH SPACE, MUST BE USED IN FILLING IN. Every item of information should be carefully supplied. Use correct age if especially important. Physicians: please write the causes of death clearly and legibly.

C51335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C51335

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd St. & Guilford Ave.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) 4
(e) Length of stay in Baltimore (~~yrs., mos., or days~~) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1914 Bolton St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Archer J. Parsons (Parsons)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Jno. A.J. Parsons
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 7, 1865
8. AGE: Years 82 | Months 2 | Days 27 | If less than one day ____ hr. ____ min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Simon Parsons
13. Birthplace Maryland

MOTHER
14. Maiden Name Harriet Anne Hagg
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 6/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Balto. Co. Md.
18 (a) Funeral director Edward O. Mitchell & Sons
(b) Address 1600 Eutaw Place
19 MAY 5 - 1947 (b) Huntingtown, Md. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4, 1947, at 5:25 A M
21. I certify that death occurred on the date above stated; that I attended deceased from April 29, 1947, to May 4, 1947, and that I last saw h.i.m. alive on May 4, 1947.

Immediate cause of death	Duration
Coronary thrombosis	?
Due to Coronary sclerosis	?
Due to	
Other Conditions Congestive heart failure	1 wk.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Edward O. Mitchell Jr.
Address Union Mem. Hosp. Date signed May 5, 1947

X

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51336

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G51336

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3735 Oakmont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HOWARD SCHWICKART

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Minna A. Schwickart

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 26, 1885

8. AGE: Years	Months	Days	If less than one day
62	2	7 17	hr. min.

9. Birthplace: Bridgeport, Conn.
(Town, county, and state)

10. Usual Occupation: Watchman

11. Industry or business: Baltimore Life Ins. Co.

FATHER
12. Name: Herman Schwickart
13. Birthplace: N. Y.

MOTHER
14. Maiden Name: Cora B. Manchester
15. Birthplace: Courtland, N. Y.

16 (a) Informant: Mrs. Minna A. Schwickart
(b) Address: 3735 Oakmont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 6, 1947 (month) (day) (year)
(c) Cemetery or crematory: Lorraine Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 MAY 5 - 1947 (Date received by registrar) Huntington Williams M.D. (Registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/3 1947, at 2 50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/2 1947 to 5/3 1947, and that I last saw h[illegible] alive on 5/3 1947

Immediate cause of death	Duration
Intracerebral hemorrhage	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Intra-
of autopsy: Intracerebral Hem.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stanley M. Iffe M.D.
Address [illegible] Date signed 5/3/47

correct age is especially important. Physicians: please write the

G51337

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

830a

G51337
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1020 William St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1020 William St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN LEWIS JACKSON

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Nora Jackson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1874

8. AGE: Years 72 | Months 4 | Days 7 | If less than one day hr. min.

9. Birthplace: Middlesex Co., Va.
(Town, county, and state)

10. Usual Occupation: Carpenter

11. Industry or business

FATHER
12. Name: Noah Jackson
13. Birthplace: Va.

MOTHER
14. Maiden Name: Annie Crittenden
15. Birthplace: Va.

16 (a) Informant: Mrs. Nora Jackson
(b) Address: 1020 William St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/6/47 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 MAY 5 - 1947 Rec'd by registrar: Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2, 1947, at 9:50P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 19 1, to May 2 1947
and that I last saw h alive on 19

Immediate cause of death: Exhaustion — Duration: 2 days
Due to: Cerebral Hemorrhage — Duration: 2 Mo
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 644 Dawson Date signed 5/7/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51338

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

Registered No. G51338

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2119 Barclay St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2119 Barclay St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY V. NELSON

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Sallie Buckey Nelson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 5, 1868

8. AGE: Years	Months	Days	If less than one day
78	5	27	hr. min.

9. Birthplace Frederick, Md.
(Town, county, and state)
10. Usual Occupation Information Clerk (Retired
11. Industry or business Maryland Casualty Co.

FATHER
12. Name John H. Nelson
13. Birthplace Frederick Co., Md.

MOTHER
14. Maiden Name Jeanette M. Adams
15. Birthplace Frederick Co., Md.

16 (a) Informant Mrs. Sallie Buckey Nelson
(b) Address 2119 Barclay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/5/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Frederick, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 MAY 5 - 1947 (Date rec'd by registrar) (c) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2, 1947, at 12:15AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 15 1947 to May 2 1947 and that I last saw h[illegible] alive on May 1 1947

Immediate cause of death	Duration
Cardiac Decompensation	7 days
Due to Carcinoma Prostate	1 year
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Helen F. Rellman M. D.
Address 6 E Biddle St Date signed 5/3/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G51339

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G51339 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 2 mos. 25 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 331 Dunkirk Rd. Balto 12 (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Charles Frederick Bauer

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: 213-03-9413

4. Sex: male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: ~~wid~~ widowed

6 (b) Name of ~~husband~~ wife: Mary Jane Bauer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 1881 (2)

8. AGE: Years: 65 | Months: 10 | Days: 2 | If less than one day: hr. min.

9. Birthplace: Pennsylvania (Town, county, and state)
10. Usual Occupation: Retired Mgr.
11. Industry or business: F. W. Woolworth Co.

FATHER
12. Name: Frederick F. Bauer
13. Birthplace: Germany

MOTHER
14. Maiden Name: ~~Louise~~ Louisa Seibert
15. Birthplace: ~~Pennsylvania~~ Germany

16 (a) Informant: Mrs. Robert Bauer
(b) Address: 331 Dunkirk Rd. Balto 12

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof: 5/7/47 (month) (day) (year)
(c) Cemetery ~~Greenmount~~ Mt. Greenwood Cem.
Location: Wilkes Barre, Pa.

18 (a) Funeral director: WM. J. TICKNER & SONS INC.
(b) Address: North & Pa. Aves., Balto. 17, Md.

19 (a) MAY 5 - 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 4 1947, at 8:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 13 1947, to May 4 1947, and that I last saw h~~im~~ alive on May 4 1947.

	Duration
Immediate cause of death: Multiple infarcts of kidneys	?
Due to: Arteriosclerosis Diabetes mellitus	many yrs. 20 yrs.
Due to: Arteriosclerotic heart disease	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy: Infarcts of kidneys

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: [signature] M. D.
Address: [illegible] Date signed: 5-6-47

correct age is especially important. Physicians: please write the

VS 150

G51340

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G51340

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5716 Highgate Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5716 Highgate Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mae A. Wells

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife: John H. Wells
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug. 10, 1900

8. AGE: Years	Months	Days	If less than one day
46	8	23	hr. min.

9. Birthplace: Tennessee (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: John Curtis
13. Birthplace: Edward Co. Ill.

MOTHER
14. Maiden Name: Stina Eimars
15. Birthplace: Edward Co. Ill.

16 (a) Informant: Mr. John H. Wells
(b) Address: 5716 Highgate Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 5, 1947 (month) (day) (year)
(c) Cemetery or crematory: Fairfax Cem.
Location: Fairfax, Va.

18 (a) Funeral director: Wm. J. Luckett & Son
(b) Address: North & Eden Aves.

19 (a) (Date rec'd by Registrar) MAY 5 1947 (b) Huntington Hollins Md. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3, 1947, at 1:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/2/47 to 5/3 1947, and that I last saw h[illegible] alive on 5/2 1947

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature: Daniel W Upton
Address 5721 York Rd Baltimore Date signed 5/4/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51341 BCH# 35170

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157 H

Registered No. G51341

Write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
Maryland General Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 805 N. Paca Street. (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Richard CARNAGGIO

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 30 1945

8. AGE: Years	Months	Days	If less than one day
1	6	3 4	..... hr. ..... min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation.....
11. Industry or business

FATHER
12. Name Salvatore Carnaggio
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Gladys Mickley
15. Birthplace Penna.

16 (a) Informant Gladys Carnaggio (Mother)
(b) Address 508 N. Paca St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 5th/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd. Baltimore Md.

18 (a) Funeral director Frank Dellis Noel
(b) Address 52 N. Morley St.

19 MAY 5 - 1947 (Date Rec'd by Registrar) (b) ..... Registrar, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3, 1947, at 8.50 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH.....
Upper respiratory infection

Due to.....

Other Conditions Congenital absence of left Kidney
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 5-3-47

104a

G51342

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G51342

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belvedere & Greenspring Ave.
(c) Hospital or institution: Levindale Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1635 Ruxton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JULIUS LEVIN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Late Dora Glyder

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1853

8. AGE: Years	Months	Days	If less than one day
94			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Samuel A. Levin
13. Birthplace Russia

MOTHER
14. Maiden Name Sonya
15. Birthplace Russia

16 (a) Informant Mrs Mollie D. Greenfield
(b) Address 1621 Eutaw place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 5/1947 (month) (day) (year)
(c) Cemetery or crematory Ohel Yakov Cong
Location Herring Run

18 (a) Funeral director Sol Levinson & Bros.
(b) Address 1124-26 W. North Ave.

19 (a) MAY 5 - 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-4 1947 at 12:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from October 1941, to 5-4 1947 and that I last saw h alive on 5-4 1947.

Immediate cause of death	Duration
Bronchopneumonia - bilateral	
Due to	
Due to	
Other Conditions Cerebral arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry N. Zeit M. D.
Address Levindale Home Date signed 5-4-47

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51343

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

56a

Registered No. ~~G51343~~

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3820 ParkHeights Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3820 ParkHeights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Birdie Lavenstein Mopsikov

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late Jacob
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 63 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Louis Lavenstein
13. Birthplace Russia

MOTHER
14. Maiden Name Belle Blacker
15. Birthplace Russia

16 (a) Informant Mrs Elsie Schapiro
(b) Address 3820 ParkHeights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 6, 1947 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run Cem
Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) MAY 5 - 1947 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

157

20. DATE OF DEATH May 5 1947 at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1946 to May 5 1947, and that I last saw her alive on May 5 1947.

Immediate cause of death Cardiac Failure & Pulmonary edema. — Duration: 2 days.
Due to Arteriosclerosis — 4 yrs.
Due to — ~~yrs~~
Other Conditions Untreated Diabetes 6 mos
Abdominal Tumor.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Reuben H. Kolman M.D. M. D.
Address 3700 Park Heights Ave Date signed May 5 1947

V S 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

51344

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. G51344

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2343 Belair Road
(c) Hospital or institution: 8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 68 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2343 Belair Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHANNAH MARY SCHWARZ

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. NONE

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Wm. F. Schwarz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 18, 1861

8. AGE: Years	Months	Days	If less than one day
85	3	13	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Samuel George Rommel
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace Germany

16 (a) Informant Mr. George Schwarz
(b) Address 2346 Belair Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/5/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS,
(b) Address NORTH AVE. & BROADWAY

19 (a) (Date rec'd by Registrar) (b) [signature]

MAY 5 1947

MEDICAL CERTIFICATION PM

20. DATE OF DEATH May 1, 1947, at 2.35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1943 to May 1 1947, and that I last saw h[illegible] alive on May 1 1947.

Immediate cause of death Coronary Thrombosis — Duration 5/1/47

Due to Ch Myocarditis — 7/1943

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
INC
(e) Means of injury
23. Signature [signature] M. D.
Address 801 W Lexington St Date signed 5/5/47

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51345

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1488

Registered No. G51345

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 735 South Carey St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Koenigbauer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	married

6 (b) Name of husband or wife John Koenigbauer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/24/17.

8. AGE: Years	Months	Days	If less than one day
30.	2	10	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name George Reynolds
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Amelia Brdr.
15. Birthplace Baltimore Maryland

16 (a) Informant John Koenigbauer
(b) Address 735 S. Carey St

17 (a) Burial - (b) Date thereof 5/8/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location German Hill Road

18 (a) Funeral director Tully & Zeiler Co.
(b) Address 1600 E. Fort Ave

19 MAY 5 - 1947 (b) Emerson Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1947 at 9:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/30 1947 to 5/4/1947, and that I last saw her alive on 5/4/1947.

Immediate cause of death	Duration
Cardio-resp. failure	
Due to Peripheral Circulatory Collapse & Acute Pulmonary Edema	3 hours
Due to Toxemia of Pregnancy - Severe pre-eclamptoxia	5 days
Other Conditions	over

(Include pregnancy within 3 months of death)

Date of operation 5/2/47

Major findings of operation: Delivered 6# stillborn Child

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas F. Turner M.D.
Address Mercy Hospital Date signed 5/4/47

VS 150

C51346 — BRANDT

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH (93)

Registered No. C51346

C.M. 110367

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1822 Eastern Ave. Z 31
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Brandt William Norvin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Anna Brandt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 16-1881

8. AGE: Years	Months	Days	If less than one day
65	6	17	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Brandt
13. Birthplace MD.

MOTHER
14. Maiden Name Josephine Johnson
15. Birthplace Md.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 5/7/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto.
Location East End of North Ave

18 (a) Funeral director Selby & Zeiler
(b) Address 403 S. Wolfe St.

19 (a) MAY 5 - 1947 Register Washington Williams, M.D.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3- 1947, at 6.15a M

21. I certify that death occurred on the date above stated; that I attended deceased from May 2 -1947 to May 3 -1947, and that I last saw him alive on May 3 - 1947.

Immediate cause of death Cardiac Failure - — Duration 4 hrs.

Due to Hypertensive CVD — 2½ yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no Post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edmund B. Beacham M. D.
Address Balto City Hosp Date signed 2 May 47

VS 150

correct age is especially important. Physicians: please write the

G51347

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G51347 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1411 Riverside Ave.
(c) Hospital or institution: 24
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1411 Riverside Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Luther Eaton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	D

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 4, 1879

8. AGE: Years	Months	Days	If less than one day
67	6	28	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William S. Eaton
13. Birthplace Md.

MOTHER
14. Maiden Name Lavina Hubbard
15. Birthplace Md.

16 (a) Informant Family
(b) Address 1411 Riverside Ave.

17 (a) B (Burial, cremation, or removal) (b) Date thereof 5/5/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Road

18 (a) Funeral director James F. McCready
(b) Address 130 E. Fort Ave.

(a) M 5 1947 (Date rec'd by local reg.) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2, 1947 at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 10, 1947 to May 2, 1947 and that I last saw h alive on May 2, 1947

Immediate cause of death: Chronic myocarditis and cardiac failure

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. B. Friedman, M.D.
Address 1319 Cathedral St. Date signed 5/4/47

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (58)

G51348 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1406 Marshall St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1406 Marshall St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura G. Mandley

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Albert E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 24, 1901

8. AGE: Years	Months	Days	If less than one day
45	8	9	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John T.A. Deck
13. Birthplace Md.

MOTHER
14. Maiden Name Laurabelle Padgett
15. Birthplace W. Va.

16 (a) Informant Family
(b) Address 1406 Marshall St.

17 (a) B (Burial, cremation, or removal) (b) Date thereof 5/6/47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn, Md.

18 (a) Funeral director John L. McCusky
(b) Address 150 E. Fort Ave.

19 (a) MAY 5 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/3/1947, at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to May 3 1947. and that I last saw h[illegible] alive on May 3 1947.

Immediate cause of death	Duration
Rheumatic Heart Disease	
Due to	
Due to	
Other Conditions Anasarca 6 weeks Uremia 2 days	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Isaac Miller M.D.
Address 1500 Pleasant St. Date signed 5/5/47.

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Especially important. Physicians: please write the causes of death clearly and legibly.

G51349

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

Registered No. G51349

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3007 Clifton Ave.,
(c) Hospital or institution:
15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3007 Clifton Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Augusta Lingerman

3 (b) If veteran, name war: Spanish-American
3 (c) Social Security Account No. 215-01-5512

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ruby E. Lingerman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 31, 1882

8. AGE: Years 65 | Months 3 | Days 1 2 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Salesman
11. Industry or business Talbot Motors

FATHER
12. Name James Vanhardt Lingerman
13. Birthplace Germantown, Pa.

MOTHER
14. Maiden Name Margaret White
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Ruby E. Lingerman
(b) Address 3007 Clifton Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-6-47 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Baltimore, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.

19 MAY 5 - 1947 (Date rec'd by registrar) (c) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2, 1947, at 4.40 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 30, 1947, to May 2, 1947, and that I last saw him alive on May 2, 1947.

	Duration
Immediate cause of death: Congestive Heart Failure	one day
Due to: Chronic myo- and endo-carditis	9
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Maurice L. Shaver M. D.
Address 3300 W. North Ave. Date signed 5/3/47

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51350

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 94a

G51350 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1016 Warwick Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Zimmerman

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-09-0543

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Mollie Zimmerman

6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) May 5th 1889

8. AGE: Years 57 | Months 11 | Days 27 28 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business Grocery Store

FATHER 12. Name Theodore Zimmerman

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Mary Nowls

15. Birthplace Baltimore Md

16 (a) Informant Mollie Zimmerman

(b) Address 1016 Warwick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/9/47 (month) (day) (year)

(c) Cemetery or crematory Baltimore National

Location

18 (a) Funeral director Charles P. Powell

(b) MAY 5 - 1947 27 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/3/47 19 ..., at 11:15 PM

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ... at ... M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John R. Davis M.D. Medical Examiner.

Date signed 5/4/47

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X

G51351

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 461

Registered No. G51351

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution: St Josephs Hospital - 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimae
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1506 E. Oliver Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Mary Elizabeth Carey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3. - 1867

8. AGE: Years	Months	Days	If less than one day
79	11	-	hr. min.

9. Birthplace New York City
(Town, county, and state)

10. Usual Occupation

11. Industry or business at Home

FATHER
12. Name James P. Carey
13. Birthplace Ireland

MOTHER
14. Maiden Name Maria Fleming
15. Birthplace Baltimore Md

16 (a) Informant Eugena Montgomery
(b) Address 1506 E Oliver St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 7 1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Road

18 (a) Funeral director John C Moran
(b) Address 3 E Baltimore St

19 (a) MAY 5 - 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/3/ 1947 at 9:40 P M M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/29 1947 to 5/3/ 1947. and that I last saw h ee alive on 5/3/ 1947.

Immediate cause of death Acute cardio-respiratory failure — Duration

Due to pulmonary embolism

Due to possible ca of rectum

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 5/1/47

Major findings of operation: rectal polyp - possible ca

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John S. Straus

Address St Josephs Hospital Date signed 5/3/47

VS 150

G51352

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. G51352

Every item of information should be carefully supplied. Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1601 Belmar Ct. (If rural give location) Belmar
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Binkey Wilson.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife John Wilson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years	Months	Days	If less than one day
50 49			hr. min.

9. Birthplace S. C. (Town, county, and state)
10. Usual Occupation H.W.
11. Industry or business

FATHER
12. Name Bruce Miller.
13. Birthplace Manning, S.C.

MOTHER
14. Maiden Name Sarah Chaney.
15. Birthplace Manning S.C.

16 (a) Informant Albert Wilson.
(b) Address 1601 Belmar Ct. Apt

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 5, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) MAY 5 1947 (Date filed by registrar) Funeral for Williams, Mrs.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-1-1947, at 7:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-23-1947 to 5-1-1947, and that I last saw her alive on 5-1-47

Immediate cause of death	Duration
Generalized Carcinomatosis.	
Due to Ovarian Carcinoma with metastasis to	
Due to Bladder - section	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles H. Kaelber M.D.
Address University Hosp. Date signed 5-1-47

VS 150

G51353

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 46B

Registered No. G51353

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 921 N. Eden St
(c) Hospital or institution: 1D
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 921 N. Eden St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harvey Tillman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
61			hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation Gardener

11. Industry or business

FATHER
12. Name Payton Harvey
13. Birthplace N. C.

MOTHER
14. Maiden Name Melvia Harvey
15. Birthplace N. C.

16 (a) Informant Katie Richerson
(b) Address 921 N. Eden St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 5, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary cem
Location Brooklyn Md

18 (a) Funeral director Clay F. Wilson
(b) Address 1000 Brenton ave

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3, 1947, at 9:30A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1945 to May 3 1947, and that I last saw h alive on May 1 1947

Immediate cause of death	Duration
Cachexia	1 yr
Due to Sarcinomatosis	1yr
Due to Cancer Stomach hist	
Other Conditions Metastases Funeral	

(Include pregnancy within 3 months of death)

Date of operation July 1946

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature
Address 1422 E Date signed 5/2/47

VS 150

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G51354

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 8/a

G51354 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Prestmann st. 15
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1708 Prestmann st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VERNON ROGERS

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/15/31

8. AGE: Years 15 | Months 4 | Days 19 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation School

11. Industry or business

FATHER
12. Name Evan Rogers
13. Birthplace Md.

MOTHER
14. Maiden Name Evelyn Harris
15. Birthplace Md

16 (a) Informant Evelyn Rogers
(b) Address 1708 Prestman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/7/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md

18 (a) Funeral director Geo. H. Kelson
(b) Address 303 Prestman St

19 (Date rec'd by registrar) MAY 5 - 1944 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-3- 1944, at 1 30 a/ M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Meningitis (acute)

Due to

Other Conditions Pulmonary edema
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 5-3-44

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651355

651355

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. 651355

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not abbreviate. Write the word "unknown" if you cannot obtain the correct answer. If the age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2422 Etting St
(c) Hospital or institution:

13

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2422 Etting St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Irene Gray

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Col.

6 (a) Single, married, widowed, or divorced. Wid.

6 (b) Name of husband or wife John Gray

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 21, 1890

8. AGE: Years 56 Months 7 Days 11 If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Jacob Collins
13. Birthplace Md.

MOTHER
14. Maiden Name Emma Waters
15. Birthplace Md.

16 (a) Informant Sadie Collins
(b) Address 2422 Etting St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-5-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Md.

18 (a) Funeral director George H. Nelson
(b) Address 1303 Priestman St

19 (a) MAY 5 - 1947 Registered by Herrington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 1947, at 7 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 14 1947 to May 1 1947, and that I last saw her alive on May 1 1947.

Immediate cause of death: Congestive Heart Failure — Duration: 3 mos.

Due to Unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 844 N. Carey, Balt., Md. Date signed 5/3/47

VS 150

G51356

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 159

G51356 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto. Co.
(c) City or town Upperco
(If outside city or town limits, write RURAL and give town)
(d) Street No.....
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Laurence Schultz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 4-27-47

8. AGE: Years | Months | Days: 8 | If less than one day ..... hr. ..... min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER 12. Name Charles Allen Schultz
13. Birthplace Md.

MOTHER 14. Maiden Name Dorothy Buell
15. Birthplace Md.

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof May 5/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Forest
Location Baltimore Md

18 (a) Funeral director Edw A Gipton
(b) Address Hampstead Md

MAY 5 1947 (b) Hampstead Williams
(Date rec'd by Local Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1947, at 8 55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1947 to May 4 1947 and that I last saw him alive on May 4 1947.

Immediate cause of death	Duration
Hemorrhage	
Atelectasis	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature D H Huggins M.D.

Address Johns Hopkins Hosp. Date signed 5-5-47

X

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important. Burial permit will not be issued unless this certificate is properly filled out.

G51357
CWK-109635

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1313

G51357
Registrar's No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 1-
(e) Length of stay in Baltimore (yrs., mos., or days) 22- 6- 28-

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. RFD 3028 Pinewood Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Edward Clark

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elaine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 6-1924

8. AGE: Years	Months	Days	If less than one day
22	6	28	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward Clark (D)
13. Birthplace Maryland

MOTHER
14. Maiden Name Viola Copen (D)
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 5/7/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Baltimore

18 (a) Funeral director Leonard J. Kuck
(b) Address 530 S. Hayford Rd.

19 (a) May 5 1947 (b)
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH May 4 1947, at 3:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 3 1947, to May 4 1947, and that I last saw him alive on May 4 1947.

Immediate cause of death	Duration
Respiratory Failure	
Due to Pulmonary tuberculosis far advanced	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: no Post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Edmund B Beacham M. D.
Address Balto City Hosp Date signed 4 May 47

X

G51358

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 186a

G51358 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution:
Univ. Hosp — 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County None
(c) City or town Baltimore 9
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1018 E. Preston St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose M. Vogt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife George W. Vogt
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) July 3 - 1868

8. AGE: Years	Months	Days	If less than one day
78	10	1	hr. min.

9. Birthplace Maryland —
(Town, county, and state)
10. Usual Occupation Hsw
11. Industry or business

FATHER
12. Name David Markley
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine Sharp
15. Birthplace Md.

16 (a) Informant Mrs. George E. Markley
(b) Address 1516 Round Hill Rd

17 (a) Burial (b) Date thereof 5-7-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore

18 (a) Funeral director L. Peck
(b) Address 5305 Harford Rd.

19 (a) 1947 (b) Filed by registrar [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-4 1947, at 2 15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-11 1947 to 5-4 1947, and that I last saw alive on 4-5 1947.

Immediate cause of death Cerebro Vasc accident — Duration

Due to

Due to

Other Conditions Fractured left femur
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation Fracture left femur (M.C.K.)
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence Feb 11 1947 at 3 M
(c) Where did injury occur? 1018 E. Preston Balto Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? None While at work? No
(Specify type of place)
(e) Means of injury Fell from chair

23. Signature [illegible] M. D.
Address Union Mem. Date signed 5-5-47
For Dr J. R. Davis, by Howard J. Malloy MD
X 106

correct age is especially important. Physicians: please write the

Dr. Gordy G51359

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G51359

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Road
(c) Hospital or institution:
Snyder's Nursing Home 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2806 Parkview Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Frances Maben

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1868

8. AGE: Years	Months	Days	If less than one day
78	9		hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name George M. Maben
13. Birthplace Md.

MOTHER
14. Maiden Name Maggie Taylor
15. Birthplace Md.

16 (a) Informant Mrs. Marion W. Donnet
(b) Address 6712 Holibird Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/5/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 (a) 1947 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2nd, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1st 1947 to May 2nd 1947, and that I last saw h[illegible] alive on May 2nd 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day
Due to Hypertension	6 years
Due to Arteriosclerosis	8 years
Other Conditions Chronic Myocarditis	3 years

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? None
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury None

23. Signature L. L. Gordy M.D.
Address 5106 Harford Rd Date signed 5-3-47

V S 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C51360
514487

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1253

Registered No. C51360

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 103 W. 20th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Waters

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-20-02

8. AGE: Years	Months	Days	If less than one day
45	1	14	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Solly Waters.
13. Birthplace Md.

MOTHER
14. Maiden Name Georgiana Anderson
15. Birthplace Md

16 (a) Informant Rhonda.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 5-7-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co.

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St.

19 MAY 5 - 1947 Washington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 1947, at 320 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 30 1947, to May 3 1947, and that I last saw h[illegible] alive on May 3 1947.

Immediate cause of death	Duration
Leukemia	2 wks.
Due to: Liver Abscesses	
Due to	
Other Conditions Uremia (?) Thrombocytopenic Purpura	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hoyt Harvey M. D.
Address Johns Hopkins Hosp. Date signed 5/6 1947

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

651361 CM 11o366 /13B Registered No. 651361

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2006 Sparks Ct. 231
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hoppe, John Adam (Adam John Hoppa)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 8-1900

8. AGE: Years 46 | Months 4 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas Hoppa
13. Birthplace Poland

MOTHER
14. Maiden Name Frances
15. Birthplace Poland

16 (a) Informant Records Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-7-47 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus Cem
Location Balto City

18 (a) Funeral director Mary Weber
(b) Address 401 S. Chester St

19 (a) MAY 5 - 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4- 1947, at 6.00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 2- 1947, to May 4- 1947, and that I last saw him alive on May 4- 1947.

Immediate cause of death Respiratory Failure - | Duration —

Due to Tuberculosis, pulmonary, far advanced. |

Due to |

Other Conditions |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no Post.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edmund B. Bealmear M.D.
Address Balto City Hosp Date signed 4 May 47

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Use only authorized abbreviations. If necessary, supplied. The

G51362

DEGRWILLO

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G51362

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 625 S. Bradford St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr
(e) Length of stay in Baltimore (yrs., mos., or days) 60 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 625 S. Bradford St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Karol Dengwillo

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Dengwillo

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 70 | Months | Days | If less than one day: hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Vincent Dengwillo
13. Birthplace Poland

MOTHER
14. Maiden Name armbrawn
15. Birthplace Poland

16 (a) Informant Mary Dengwillo
(b) Address 625 S. Bradford St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-6-47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto. County

18 (a) Funeral director John M. Welby
(b) Address 1 E. Chester Street

19 MAY 5 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION 1055

20. DATE OF DEATH May 2, 1947, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1 1947 to May 2 1947. and that I last saw h alive on May 2 1947

	Duration
Immediate cause of death: Acute Bronchial Dilatation	1 day
Due to: Coronic Asthma	6 mos.
Due to: Chronic Myocarditis	34 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John V. Negwillo

Address 1802 Eastern Ave Date signed 5-3-47 (M. D.)

G51363

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G51363

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 420 S. Ann Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 420 S. Ann St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Chmielewski

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-03-4863

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Wladyslawa Chmielewski
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Victor Chmielewski
13. Birthplace poland

MOTHER
14. Maiden Name Maryanna Szeborowska
15. Birthplace poland

16 (a) Informant Mrs Wladyslawa Chmielewski
(b) Address 420 S. Ann Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-6-47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 407 Chester St Huntingtown Williams Md

19 MAY 5 - 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/1/47, at 9 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 5/1/47 to 5/1/47. I last saw h[illegible] alive on 5/1/47.

Immediate cause of death: Lobar pneumonia — Duration 4 days

Due to

Due to

Other Conditions: Chronic myocarditis & Sclerosis of Coronary

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 2/2
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 5/1/47 at M
(c) Where did injury occur? 420 S. Ann St Balto Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fell Struck by Ladder

23. Signature Albert A. Tikovsky
Address 2939 Fleet Ave Date signed 5/2/47

Approved by Dept Statistician

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

651364

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. 651364

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2205 W. Pratt St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2205 W Pratt St.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Adame

3 (b) If veteran, name war None

3 (c) Social Security Account No. 248-07-6969

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) October 29, 1888

8. AGE: Years 58 | Months 6 | Days 4 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation Seamstress

11. Industry or business Butler Bros.

FATHER
12. Name Henry Adame
13. Birthplace Germany

MOTHER
14. Maiden Name Jennie Thomas
15. Birthplace Maryland

16 (a) Informant Carrie Adame
(b) Address 2205 W. Pratt St.

17 (a) Burial (b) Date thereof 5-6-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore Maryland

18 (a) Funeral director George L. Schwab
(b) Address 2167 Frederick Ave

19 (a) MAY 5 - 1947 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3, 1947, at 11:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1946, to 4/3 1947, and that I last saw h-- alive on 4/3 1947

Immediate cause of death Carcinoma Liver — Duration 6 mo.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward L. Kaercher, M.D.

Address 1847 W. North Ave Date signed 5/6/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

G51365 MARY E. Stevens G51365

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 926 Bennett Pl
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 926 Bennett Pl (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E Stevens

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1891

8. AGE: Years 55 | Months 10 | Days 22 | If less than one day hr. min.

9. Birthplace Cambridge, Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Joseph Stevens
13. Birthplace Md

MOTHER 14. Maiden Name Josephine Wring
15. Birthplace Md

16 (a) Informant Mrs Sarah Nichols
(b) Address 926 Bennett Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-6-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore - Md

18 (a) Funeral director Mrs Frances A. Kennedy
(b) Address 578 W. Biddle St

19 (a) MAY 5 - 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1947 at 12:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1947 to May 7 1947 and that I last saw h[er] alive on May 2 1947.

Immediate cause of death: Cerebral Hemorrhage — Duration 2 dy

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address Date signed 5/7/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G51366 BC# G77634 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 159 ✓ Registered No. G51366

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga & Calvert Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 19 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore ✓
(If outside city or town limits, write RURAL and give town)
(d) Street No. 500 N. Glover St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Riley (Twin)
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Newborn
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 5/3/47
8. AGE: Years | Months | Days | If less than one day 19 hr. — min.
9. Birthplace Baltimore, Baltimore Md. (Town, county, and state)
10. Usual Occupation Newborn
11. Industry or business

FATHER
12. Name Joseph Paul [redacted] Riley
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Lucretia Hillmon
15. Birthplace Hartford County, Md.

16 (a) Informant Joseph Paul Riley
(b) Address 500 N. Glover St, Balt. Md
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 6-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd
18 (a) Funeral director John A. Miller
(b) 2311 Jefferson St
19 (a) MAY 5 1947 (b) Huntington Wills
(Date rec'd by registrar)

MEDICAL CERTIFICATION
20. DATE OF DEATH May 4, 1947, at 6 10 P M
21. I certify that death occurred on the date above stated; that I attended deceased from May 3, 1947, to May 4 1947. and that I last saw him alive on May 4 1947.
Immediate cause of death Prematurity — Duration 19 hrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature C. L. Delphi M. D.
Address Mercy Hospital Baltimore 2, Md. Date signed 5/5/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

VS 150

X

G51367

BALTIMORE CITY HEALTH DEPARTMENT

BCH # D 77635 CERTIFICATE OF DEATH 159

Registered No. G51367

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga & Calvert Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 28 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 500 Clover St
(If no street address, give rural route location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Boy Riley (Twin)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Newborn

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/3/47

8. AGE: Years	Months	Days	If less than one day
		1	+ 28 hrs. — min.

9. Birthplace Baltimore, Balt. Md.
(Town, county, and state)

10. Usual Occupation Newborn

11. Industry or business

FATHER
12. Name Joseph Paul Riley
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Lucretia [redacted] Hillman
15. Birthplace Hartford County, Md.

16 (a) Informant Joseph Paul Riley
(b) Address 500 N. Clover St. Balt. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 6-47 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Boland Rd.

18 (a) Funeral director John A. Miller
(b) Address 6234 Jefferson Blvd

19 (a) MAY 5 1947 (Date rec'd by registrar) (b) Huntingtown Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1947, at 3:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 3, 1947 to May 5 1947.
and that I last saw him alive on May 5 1947.

Immediate cause of death: Prematurity, 3 lbs. — Duration 28 hrs.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. L. Jenkins M. D.
Address Mercy Hospital Date signed 5/5/47
Baltimore, 1947

VS 150

G51368

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G51368

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 807 Hollins St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 807 Hollins St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emma P. Smithson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Ferdinand Hynes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1st 1866

8. AGE: Years 81 | Months 1 | Days 3 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation House work

11. Industry or business at home

FATHER — 12. Name Hezekiah Smithson
13. Birthplace Md

MOTHER — 14. Maiden Name Unknown
15. Birthplace Md.

16 (a) Informant Mrs. Maynard Hynes
(b) Address 807 Hollins St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/7/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location

18 (a) Funeral director John F. Cowan & Son
(b) Address 901-903 Hollins St.

19 MAY 5 1947 Huntington Williams, M.D. Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4th 1947, at 12:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/28 1947 to 5/4 1947 and that I last saw h[illegible] alive on 5/4 1947

Immediate cause of death	Duration
(a) Acute Coronary Failure	1 Da
Due to (b) Arteriosclerosis	
Due to (c) Cerebro Vascular Disease	5 yr
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph L. Lankards M.D.
Address 6 W. Madison St Balto Md Date signed 5/5/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51369

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

G51369 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5218 Cuthbert Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5218 Cuthbert Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie F. Small

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race W.

6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Walter L. Small

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 30 1863

8. AGE: Years 84 Months 0 Days 2 If less than one day hr. min.

9. Birthplace Bath, Maine
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name William Ford
13. Birthplace Harford Co. Maryland

MOTHER 14. Maiden Name Ellen Starbird
15. Birthplace Maine

16 (a) Informant Mrs. Florence Small
(b) Address 5218 Cuthbert Ave.

17 (a) Burial (b) Date thereof 5-5-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn, Maryland

18 (a) Funeral director Sterling Byers
(b) Address 5005 Park Heights Ave

19 (a) Washington Williams
(Date rec'd by registrar)

MAY 5 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2, 1947, at 5 A M 35

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1946 to May 2 1947 and that I last saw h alive on May 1 1947

Immediate cause of death: (1) Uremia - Sclerosis — Duration: Unknown

Due to Exhaustion — 3 mos

Due to Chronic Mitral Endocarditis — unknown

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. B. Connor M. D.

Address 7201 Rockdale Date signed 5-5-47

X

Be sure age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51370 — BALTIMORE CITY HEALTH DEPARTMENT — G51370 Registered No.

16 CH 17204 CERTIFICATE OF DEATH 161a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 532 - W. Cross St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 532 W. Cross St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Guard Augustus Taylor
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4 29 47

8. AGE: Years	Months	Days	If less than one day
		1	4 hr. 8 min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER — 12. Name Melvin W. Taylor
13. Birthplace Balto; Md.

MOTHER — 14. Maiden Name Rosalee Johnson
15. Birthplace Balto; Md.

16 (a) Informant Mother
(b) Address 532 W. Cross St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 1 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn Md

18 (a) Funeral director Elroy B. Wilson
(b) Address 1014 Hamburg Ave Huntingtown Anne Arundel Co Md

MAY 5 - 1947 (Date rec'd by registrar) (c) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1947, at 11:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 19..., to 19..., and that I last saw h... alive on 19...

Immediate cause of death	Duration
Congenital Atelectasis.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. McK. Greeley M.D.
Address 756 - Dolphin St Date signed 5/2/47

VS 190

G51371 ✓ G51371

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1016 Bruntly ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1016 Bruntly ave (If rural give location)
(e) Citizen of foreign country? .....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Catherine Nettles

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Sep.

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 10, 1890

8. AGE: Years	Months	Days	If less than one day
56 57	10	22	..... hr. ..... min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name Katie Robinson
15. Birthplace Baltimore Md

16 (a) Informant John Grain
(b) Address 1016 Bruntly ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 6 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1010 Bruntly Ave

19 (a) ..... (b) Registrar Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-2 1947 at 9A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/26 1947 to 5/2 1947 and that I last saw h.... alive on 5/1 1947

Immediate cause of death — Duration

Mitral Regurgitation

Due to .....

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature B. N. Hatcher M. D.
Address 515 147 - 12th Pl. Date signed ..... M. D.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MAY 5 1947

VS 150

1372 651372

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1640 E. 32nd St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 M
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1732 E 30th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Stoffregen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Male	White	Widowed

6 (b) Name of ~~husband or~~ wife Eva C. Stoffregen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13th 1882

8. AGE: Years	Months	Days	If less than one day
64	10	20	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Henry F. Stoffregen
13. Birthplace Germany

MOTHER
14. Maiden Name Rose (Unknown)
15. Birthplace Germany

16 (a) Informant Mrs Everitt Hill
(b) Address 1640 E. 32nd St.

17 (a) Burial (b) Date thereof 5/6/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1640 St Paul St.

19 (a) MAY 6 – 1947
(Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3rd 1947, at 4 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1947, to 3 May 1947, and that I last saw him alive on 3 May 1947.

Immediate cause of death Generalized Carcinomatosis

Due to Carcinoma Sigmoid
Due to Metastasis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation May 46
Major findings of operation Ca. of Sigmoid & Metastasis.
of autopsy

Duration
1 YR.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Louis Vogel Jr. M.D.
Address 1204 E. 33rd St Date signed

X 5-3-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51373 ✓ X G51373

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7716 Park Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Hupp

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: George E. Hupp
(c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) Jul. 2, 1853

8. AGE: Years 64 | Months 3 | Days 2 | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business Retired

FATHER
12. Name Francis Orrell
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Florence E. Stewart
15. Birthplace Baltimore Md

16 (a) Informant Richard Orrell
(b) Address Baltimore Md

17 (a) Burial (b) Date thereof May 7 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville (Balto Md)

18 (a) Funeral director Wm Cook Inc
(b) Address Balto Md

19 MAY 6 - 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1947, at 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1947, to May 4 1947, and that I last saw h[illegible] alive on May 4 1947.

Immediate cause of death	Duration
Cardiac Failure	
Due to Hypertensive Cardio-Vascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Rocco L. Lafaretta M. D.
Address L. Balto. Gen. Hosp. Date signed 5-6-47

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item must be answered. If information cannot be secured, explain why. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

51374

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G51374

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7104 Harford Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7104 Harford Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eva B Wilson

3 (b) If veteran, name war W

3 (c) Social Security Account No. none

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 10, 1886

8. AGE: Years 61 Months 0 Days 24 If less than one day hr. min.

9. Birthplace Dorchester Co Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

MOTHER / FATHER

12. Name John Wilson

13. Birthplace Md

14. Maiden name Mary Parks

15. Birthplace Md

16 (a) Informant Mrs Francis M Bradham

(b) Address 7104 Harford Rd

17 (a) Funeral (Burial, cremation, or removal) (b) Date thereof 5-7-47 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore Md

18 (a) Funeral director Wilson & Son Inc

(b) Address 1217 E Fayette St

MAY 6 - 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1947, at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 3 1946 to May 4 1947, and that I last saw h[illegible] alive on 5-4-47 19

Immediate cause of death: Terminal bronchopneumonia

Due to Cerebral Thrombosis

Due to Chronic Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
1-2 Yr

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr [illegible]

Address 642 N. Mt. Blvd Date signed 5-3-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

51375

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G51375
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2100 Eagle Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2100 Eagle Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel J. Suter

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	213-05-9621

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Alice
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9, 1884

8. AGE: Years	Months	Days	If less than one day
62	11	26	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Starter
11. Industry or business Balto. Transit Company

MOTHER / FATHER
12. Name George Suter
13. Birthplace Baltimore, Maryland
14. Maiden Name Catherine Kelley
15. Birthplace

16 (a) Informant Alice Suter
(b) Address 2100 Eagle Street

17 (a) Burial (b) Date thereof 5/8/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) MAY 6 - 1947 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5, 1947, at 3:10 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1945 to 5-5-1947 and that I last saw h[illegible] alive on 5-3-1947.

	Duration
Immediate cause of death Uremia	6 mo.
Due to Cardio-Renal Disease	1½ yr.
Due to Hypertension - Arteriosclerosis	24 yr.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Peterman Rixon M. D.
Address 2424 Eutaw Place Date signed 5-5-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G51376

1376 ✓ 1314

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important. Any person who wilfully supplies...

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4608 Marble Hall Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Corrigan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 10, 1866

8. AGE: Years	Months	Days	If less than one day
80	4	25	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Saleslady - retired
11. Industry or business O'Neil & Company

FATHER
12. Name Francis Corrigan
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Doyle
15. Birthplace Maryland

16 (a) Informant Douglas Carroll
(b) Address 4608 Marble Hall Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/7/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1617 St. Paul Street

19 (a) MAY 6 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5, 1947, at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1947 to May 5 1947 and that I last saw h. alive on May 5 1947

Immediate cause of death: Arteriosclerotic Cardiovascular renal disease — Duration: 4 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Dolan
Address 6007 Harford Rd Date signed 5/8/47 (M.D.)

1877

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered No. G51377

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 128 N. Port Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore rt St
(If outside city or town limits, write RURAL and give town)
(d) Street No. 128 N. Port Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Zeller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Helen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 6 1880

8. AGE: Years	Months	Days	If less than one day
66	8	29	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Street-cleaner
11. Industry or business Baltimore City

FATHER
12. Name Willian Zeller
13. Birthplace Germany

MOTHER
14. Maiden Name Bernadine
15. Birthplace Germany

16 (a) Informant Valentine Zeller
(b) Address 1417 Andre Street

17 (a) burial (b) Date thereof 5/8/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

MAY 6 - 1947 (Huntington Williams M.D.)
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5, 1947, at Noon M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/26/28 1946, to 5/2 1947 and that I last saw h alive on 5/2 1947.

Immediate cause of death — Duration

Carcinoma of Bladder — 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. J. Faulkner M.D.
Address 100 N. Milton Ave. Date signed 5/7/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G51378

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G51378

A8-110278 B# D 78189 160a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 hrs .55min
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1529 McKean Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Baby Boy Parker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 29-1947

8. AGE: Years | Months | Days | If less than one day: 22 hr. 55 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Rufus Parker
13. Birthplace Va.

MOTHER
14. Maiden Name Elvira Holt
15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Cremated (b) Date thereof 5-1-47
(Burial, cremation, or removal) @ 3 pm (month) (day) (year)
(c) Cemetery or crematory B.C.H.
Location 4940 Eastern ave.

18 (a) Funeral director
(b) Address

19 MAY 6 - 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION PM

20. DATE OF DEATH April 29 1947, at 11.55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-29- 1947 to 4-29 1947, and that I last saw him alive on 4-29 1947.

	Duration
Immediate cause of death: Cerebral Anoxia	1 Day
Due to:	
Due to: Paraldehyde for Mother's Pre-eclampsia	2 days
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Findings of autopsy: Anoxia & Cerebral Hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Julian P. Griffin M. D.
Address Balt. City Hosps. Date signed 2 May '47

X

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51379 BCH 077726

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160 C

Registered G51379

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos., or days~~) 1hr.
(e) Length of stay in Baltimore (~~yrs., mos., or days~~) 1hr.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE 18
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5 WENDOVER RD
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME BABY GIRL ROBERTS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-30-47

8. AGE: Years	Months	Days	If less than one day
0	0	0	1 hr. — min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name JOHN THOMAS ROBERTS jr
13. Birthplace N.C

MOTHER
14. Maiden Name HAZEL JEAN RHODES
15. Birthplace N.C

16 (a) Informant HOSPITAL RECORDS
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 (a) (Date) MAY 6 1947 by Registrar Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-30 1947, at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-30 1947 to 4-30 1947, and that I last saw h~~e~~r alive on 4-30 1947.

Immediate cause of death	Duration
PREMATURITY	
Due to	
Due to	
Other Conditions PLACENTA PRAEVIA, Marginal PLACENTA PREMATURE SEPARATION of the PREMATURE Rupture of Membranes	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E R Chamberlin M. D.
Address Union Memorial Hosp Date signed 4-30-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

159

C51380

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. C51380

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Laynes + Dukeland
(c) Hospital or institution: West Balto Gen Hosp. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3310 Worchester Ct.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sophie Ballan

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Nicholas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years	Months	Days	If less than one day
48			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Home Work
11. Industry or business

FATHER 12. Name Barney Israel
13. Birthplace Russia

MOTHER 14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Husband
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-6-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Old Rd + Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto St.

MAY 6 - 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 May 19 47 at 2:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4 May 19 47 to 5 May 19 47 and that I last saw h alive on 5 May 19 47.

Immediate cause of death Shock.
Due to Hemorrhage - Internal
Due to Hypertensive C.V. Renal Dis.
Other Conditions Congestive Failure
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lester A. Hall M.D. M. D.
Address West Baltimore Gen Hosp Date signed 5/7/47

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

51381

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BC# b 79203

159

G51381
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 923 Madison Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 923 Madison Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Loretta Bevans

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race N | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-25-47

8. AGE: Years | Months 7 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county and state)

10. Usual Occupation Infant

11. Industry or business

FATHER 12. Name Hercules Johnson
13. Birthplace N.C.

MOTHER 14. Maiden Name Dorothy Bevans
15. Birthplace Md

16 (a) Informant Dorothy Bevans
(b) Address 923 Madison Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1947 at 6A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-25- 1947 to 4-31- 1947.
and that I last saw her alive on 4-29 1947.

Immediate cause of death	Duration
(a) Asphyxia	
Due to	
(b) Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William D. Miller
Address Univ. Hosp. Date signed 4-31-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

APR 30 1947
Commissioner of Health

MAY 6 1947
Huntington Williams M.D.
Registrar

X

G51382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G51382

309

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton + Wilkens Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 6210 Frederick Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jack Williams.
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex M.
5. Color or race W
6 (a) Single, married, widowed, or divorced. Widowed
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1884
8. AGE: Years 63 Months Days If less than one day hr. min.
9. Birthplace Ky. (Town, county, and state)
10. Usual Occupation Foreman.
11. Industry or business Consolidated Gas Elec Co
FATHER 12. Name Lenn.
13. Birthplace
MOTHER 14. Maiden Name Mary Naylor
15. Birthplace Kentucky
16 (a) Informant Hospital Records
(b) Address
17 (a) Cremation (b) Date thereof May 6 1947 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3501 Frederick Rd
18 (a) Funeral director Harry A Wilson
(b) Address 4101 Edmondson Ave
19 (a) MAY 6 - 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 May 1947, at 3A M
21. I certify that death occurred on the date above stated; that I attended deceased from 23 April 1947 to 3 May 1947, and that I last saw h alive on 3 May 1947
Immediate cause of death Respiratory Failure — Duration
Due to 1. Uremia — 8 days
Due to 2. HYPERTENSIVE CARDIO-VASCULAR DISEASE — Years
Other Conditions SYPHILIS — Years
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James E. Hamill M.D.
Address St Agnes Hosp. Date signed 5 May 47

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

51383

BCH 878614

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

✓ C51383 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 1514 Division St.
(b) Street address ~~2707 Spellman Rd.~~
(c) Hospital or institution: PROVIDENT 25

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (Cherry Hill) (If outside city or town limits, write RURAL and give town)
(d) Street No. 2707 Spellman Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Gregory Clark

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: N | 6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/21/47

8. AGE: Years | Months | Days: 6 7 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name William T. Clark
13. Birthplace Balto., Md

MOTHER
14. Maiden Name Virginia Raleigh
15. Birthplace Greensboro, N. C.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Local Johns Hopkins Medical School MAY 1 1947 Commissioner of Health

18 (a) Funeral director
(b) Address

19 MAY 6 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/25 1947, at 6:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/25 1947 to 4/25 1947, and that I last saw him alive on 4/25 1947.

Immediate cause of death	Duration
Dehydration	
Due to Diarrhea	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence 4/24/47 at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Lourie, M. D.
Address 100 Druid Park Date signed 4/27/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item is important. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

G51384

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

#77321 160a

✓ G51384 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave 16
(c) Hospital or institution West Balto Gen. Hosp.
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 2
(e) Length of stay in Baltimore (~~yrs., mos., or~~ days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town: Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3025 Fleetwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Petrul

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/27/47

8. AGE: Years | Months | Days: 2 | If less than one day: hr. 45 min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Alfred Petrul
13. Birthplace Stamford Conn.

MOTHER
14. Maiden Name Florence Covey
15. Birthplace N.Y.

16 (a) Informant Alfred Petrul
(b) Address 3025 Fleetwood Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo MAY 1 1947

18 (a) Funeral director Commissioner of Health

(b) Address

MAY 6 1947 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29, 1947, at 1.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/27/47 19 to 4/29/47 19; and that I last saw h[illegible] alive on 4/29/47 19

Immediate cause of death Premature birth
and intracranial hemorrhage

Due to end to twin

Compound presentation

Due to

Other Conditions Prolonged 3rd stage ether anesthesia
(Include pregnancy within 3 months of death)

Date of operation 4/27/47

Major findings of operation:

of autopsy:

Duration: 2 days.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Grayson S. Waldrop M. D.
Address West Balt. Gen. Hosp. Date signed 4/29/47

VS 150

PLEASE WRITE PLAINLY, with unfading ink. Use no abbreviations or ditto marks. Be sure to state the causes of death clearly and legibly. Certify to only one cause on each line. Do not enter the mode of dying, such as heart failure, asphyxia, anemia, or uremia, without stating the cause which produced it. Indefinite or unsatisfactory answers cannot be accepted. If the deceased was a woman, whether single, married, widowed, or divorced, the maiden name should be given. The information called for in items 12 to 15 is required for the identification of the certificate, and should be obtained from the most reliable source. If exact date of birth is unknown, the age at last birthday should be given in years, or if under one year, in months, days, hours, or minutes. The space for "Length of stay" should be filled in only in case of nonresidents. The certificate should be filled out, signed, and returned to the funeral director in the shortest possible time. Physicians: please write correct age is especially important.

City Reg # B83224 Deposited

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G51685

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 222 N. Pine St Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby boy Douglas.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/27/47

8. AGE: Years	Months	Days	If less than one day
			1 hr. 5 min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Infant.

11. Industry or business

FATHER
12. Name Leslie Clark
13. Birthplace ?

MOTHER
14. Maiden Name Nannie Brown
15. Birthplace Md.

16 (a) Informant Sophie Corbin (aunt)
(b) Address 222 N. Pine St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School MAY 2 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAY 6 1947 Huntington Williams MD
(Date rec'd by Registrar) (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-27 1947, at 3.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-27 1947 to 4-27 1947 and that I last saw him alive on 4-27 1947

Immediate cause of death Prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gerald Martin M. D.
Address Univ. Hospital Date signed 4-27-47

G51386 BC# 283624 BALTIMORE CITY HEALTH DEPARTMENT 159 G51386
CERTIFICATE OF DEATH Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 922 W. Baltimore (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy LeBon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26, 1947

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Rev. L. LeBon
13. Birthplace Md

MOTHER 14. Maiden Name Barlay Straener
15. Birthplace La

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo MAY 2 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAY 6 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-27-47, at 10:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 27 1947 to April 27 1947 and that I last saw alive on April 27 1947.

Immediate cause of death	Duration
Aspiration Pneumonia	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. Driggs M. D.
Address Johns Hopkins Hospital Date signed April 29/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

651387

B# b76878

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. 651387

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: The Johns Hopkins Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 623 W. Baltimore Street
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME McCain

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 25, 1947

8. AGE: Years	Months	Days	If less than one day
		2	..... hr. ..... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation.....
11. Industry or business

FATHER
12. Name Larkin McCain
13. Birthplace

MOTHER
14. Maiden Name Doris Tracy
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address

17 (a)..... (b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory.....
Location Johns Hopkins Medical Schoo MAY 2 1947

18 (a) Funeral director Commissioner of Health
(b) Address.....

19 MAY 6 1947 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 1947, at 6:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 25 1947, to April 27 1947, and that I last saw her alive on April 27 1947.

Immediate cause of death..... Duration
Atelectasis, bilateral .....
.....
Due to prematurity .....
.....
Due to.....
.....
Other Conditions.....
(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M.
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature J. Russell Nolan
Address Johns Hopkins Hospital Date signed 4-27-47 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

651288 651288

BALTIMORE CITY HEALTH DEPARTMENT

BC# B-77165 CERTIFICATE OF DEATH 160c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address E. Monument St
(c) Hospital or institution: Sinai Hosp Balto - Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2hrs 10
(e) Length of stay in Baltimore (yrs., mos., or days) 2hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto - 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 911 E. Preston St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Fox

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	wht.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APR. 30, 1947

8. AGE: Years	Months	Days	If less than one day
NB.			2 hrs 10 min.

9. Birthplace Balto - Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Everett Fox
13. Birthplace AHKAI - W. Va

MOTHER
14. Maiden Name June Oxier
15. Birthplace Cars - W. Va.

16 (a) Informant June Fox
(b) Address 911 E. Preston St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo MAY 5 1947

18 (a) Funeral director Commissioner of Health

(b) Address

19 MAY 6 1947 (Date received by registrar) Hamilton Williams MD

VS Form 10-50 [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH APR. 30, 1947, at 5½ M

21. I certify that death occurred on the date above stated; that I attended deceased from APR. 30 1947 to APR. 30 1947, and that I last saw h[illegible] alive on APR. 30 1947.

Immediate cause of death: Asfixia Duration

Due to: Aspiration of cord

Due to: Predisposed, were

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel Aaron MD
Address Sinai Hospital Date signed 5/3/47

Please write plainly, using ink. Punctuation marks are necessary. Be sure the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1389 BALTIMORE CITY HEALTH DEPARTMENT 651389
B# 73735 CERTIFICATE OF DEATH 160c Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6 Monument W
(c) Hospital or institution Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 10 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Dundalk-22 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1908 Tyler Rd. (If rural, give location)
(e) Citizen of foreign country no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Donna Hummelman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race wht. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 22, 1947

8. AGE: Years 0 | Months | Days | If less than one day 10 hrs. min.

9. Birthplace Balto - Md (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Chas. Wm. Hummelman
13. Birthplace Balto - Md.

MOTHER 14. Maiden Name Madeline Hayfelty
15. Birthplace Balto - Md.

16 (a) Informant Chas Hummelman
(b) Address 1908 Tyler Rd. Dundalk

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo MAY 5 1947
Commissioner of Health

18 (a) Funeral director
(b) Address

19 MAY 6 1947 (Date rec'd by registrar) Clayton Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 22 1947 at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 22 1947 to Mar 22 1947 and that I last saw h[illegible] alive on Mar. 22 1947

	Duration
Immediate cause of death: Respiratory failure	
Due to: Atelectasis	
Due to: Premature separation of Placenta	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Undefine the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Kaplan M. D.
Address Sinai Hospital Date signed 4-8-47

PLEASE WRITE PLAINLY WITH INK AND DO NOT ERASE. Any error or omission should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G51390

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G51390

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Redwood & Green
(b) Street address University Hospital
(c) Hospital or institution: University 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1424 Harlem Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country –

3 (a) FULL NAME Hanson Adams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife Leona

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-27-[illegible]

8. AGE: Years	Months	Days	If less than one day
55	9	8 9	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Messenger

11. Industry or business

FATHER
12. Name James Adams
13. Birthplace Md.

MOTHER
14. Maiden Name Malinda Ward
15. Birthplace Md.

16 (a) Informant Leona Adams
(b) Address 1424 Harlem Ave

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 5-8-47 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Balto. Co.

18 (a) Funeral director Samuel W. Sullivan, Jr.
(b) Address 1011 N. Arlington Ave.

19 (a) (b) Huntington Williams, M.D. Registrar
(Date received by registrar)

MAY 6 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1947 at 11 00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-5 1947, to 5-5 1947 and that I last saw h[illegible] alive on 5-5 1947

Immediate cause of death: Cardiac failure — Duration

Due to Arteriosclerotic C-V Disease

Due to Cardiac hypertrophy Arteriosclerosis

Other Conditions Pulmonary edema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature H. Morris Carl M.D.

Address University Hosp. Date signed 5-5-47

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G51391

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G51391

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1303 Druid Hill Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1303 Druid Hill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elsie Pitts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12, 1876

8. AGE: Years	Months	Days	If less than one day
70	9	23	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Reuben Blunder
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Carpenter
15. Birthplace Md.

16 (a) Informant Mrs. Dolley Scott
(b) Address 1102 W. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-10-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion Cem.
Location Anne Arundel Co., Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

MAY 6 - 1947 (Date rec'd by local registrar) (b) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH May 4, 1947, at 11:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/2 1947 to 5/4 1947 and that I last saw h er alive on 5/4 1947

Immediate cause of death Myocardial Degeneration — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. Franklin Phillips

Address 1543 Penna. Ave. Date signed May 5/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51392

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G51392

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 531 W. Hoffman St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 531 W. Hoffman St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth McDaniel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24, 1866

8. AGE: Years	Months	Days	If less than one day
80	9	12	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name John Smith
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Emma Lee
15. Birthplace Virginia

16 (a) Informant Mrs. Ethel Harris
(b) Address 531 W. Hoffman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-8-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Kemahy
(b) Address 578 W. Biddle St.

19 (a) MAY 6 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 4 1947 to May 5 1947 and that I last saw her alive on May 4 1947.

Immediate cause of death	Duration
Congestive heart failure	3 mo.
Due to Hypertensive cardio-vascular disease	Unk.
Due to	
Other Conditions Arteriosclerosis	Unk.

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. McDonald M.D.
Address 844 N. Carey St. Date signed 5/5/47

V S 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G51393

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1526 Penna. Ave
(c) Hospital or institution: 14

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1526 Penna. Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isaiah Scott, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bessie F. Scott
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4, 1889

8. AGE: Years 58 | Months 1 | Days 1 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Insurance Agent-

11. Industry or business

FATHER
12. Name Isaiah Scott Sr.
13. Birthplace Md.

MOTHER
14. Maiden Name Harriett Blake
15. Birthplace Md.

16 (a) Informant Mrs. Bessie Scott
(b) Address 1526 Penna. Ave.

17 (a) Burial (b) Date thereof 5-9-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory National Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 MAY 6 - 1947 (Date rec'd by registrar) Interior for Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5, 1947, 12:35 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/29/1947 to 5/5/1947 and that I last saw him alive on 5/4/1947

Immediate cause of death: Chronic Myocarditis — Duration: 14yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]
Address 578 W. Biddle St. Date signed 5/5/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V S 150

G51394

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G51394

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 652 W. Saratoga St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 652 W. Saratoga St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Estelle Bynum

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 1900

8. AGE: Years	Months	Days	If less than one day
46	7		hr. min.

9. Birthplace Wilson, North Carolina
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Wilson, N. C.

MOTHER
14. Maiden Name Unknown
15. Birthplace Wilson, N. C.

16 (a) Informant Mrs. Daisy Bynum
(b) Address 652 W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-8-47 (month) (day) (year)
(c) Cemetery or crematory Roundtree Cem.
Location Wilson, N. C.

18 (a) Funeral director Mrs Frances A. Hemsley
(b) Address 578 W. Middle St.

19 (a) MAY 6 - 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4, 1947, at 11:30 A

21. I certify that death occurred on the date above stated, that I attended deceased from 4/27 1947 to 5/4 1947
and that I last saw her alive on 5-3 1947

Immediate cause of death Cerebral Thrombosis — Duration 7 Days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature B. F. Hatcher

Address 1725 Pulaski Ave Date signed 5/5/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51395

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 110 B

Registered No. G51395

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: Church Home + Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Sparrows Point (If outside city or town limits, write RURAL and give town)
(d) Street No. 508 D St (If rural give location)
(e) Citizen of foreign country? ? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs Sarah Marchant

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mr Henry Marchant

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Feb 26 1873

8. AGE: Years 74 | Months 2 | Days 14 | If less than one day ..... hr. ..... min.

9. Birthplace England (Town, county, and state)

10. Usual Occupation Home maker

11. Industry or business Home maker

FATHER
12. Name Mr Christopher Driver
13. Birthplace England

MOTHER
14. Maiden Name Mrs Elizabeth Morgan
15. Birthplace England

16 (a) Informant Mr Henry Marchant
(b) Address 508 D St Sparrows Pt

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 7/42 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Balto Co Md

18 (a) Funeral director Welsh Funeral Home
(b) Address 2007 Orleans

19 MAY 6 - 1942 Huntington Williams M.D. (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1942, at 11 03 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 4 1942 to May 4 1942, and that I last saw her alive on May 4 1942

	Duration
Immediate cause of death: Pulmonary edema + Shock	1 day
Due to: Hydrothorax Left.	10 days
Due to: Cardiac insufficiency	20 days
Due to: Subacute bacterial endocarditis - (Strep viridans)	90 days
Other Conditions: Arteriosclerosis general	20 yrs

(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury .....

23. Signature David Bachman
Address ..... Date signed May 5 42 (M. D.)

VS 150

X

Please write clearly and legibly. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

G51396

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164E

Registered No. G51396

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 952 E. Fort Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis W Elmer Spies

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4 1881

8. AGE: Years	Months	Days	If less than one day
65	11	-	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business retired

FATHER
12. Name Louis W Spies
13. Birthplace Balto

MOTHER
14. Maiden Name Martha Wendell
15. Birthplace Balto

16 (a) Informant Mrs Andrew Schmidt
(b) Address 222 Mt Olivet Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 7 '47 (month) (day) (year)
(c) Cemetery or crematory Balto Cem
Location North Ave

18 (a) Funeral director Wehr Funeral Home
(b) Address 2108 Arlington Ave

19 (c) MAY 6 – 1947 Huntington Williams M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/4 1947, at 4:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to

Other Conditions Crushed pt of Chest - Compound fracture rt. tibia
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5/2/47 at 3:30 P.M.
(b) Where did injury occur? 1913 Eutaw Place
(c) Did injury occur at home, on farm, industrial place, in public place? Nursing home While at work? No
(d) Means of injury Jumped from 3rd floor window

23. Signature C. F. Schmidt M.D.
Medical Examiner.
Date signed 5/5/47

VS 131

G51397

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G51397 ✓ Registered No.

1-E. Lager St.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1 E. Lager St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1732 Division St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles P. Butler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Lula Marshall

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 26, 1885

8. AGE: Years 61 | Months 5 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Hauler

11. Industry or business Maryland Club

FATHER 12. Name Louis P. Butler

13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Jennie Johnson

15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Lula Marshall Butler

(b) Address 1732 Division St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 6 1947 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial Park

Location Baltimore Co. Md.

18 (a) Funeral director Geo. H. Holland

(b) Address 1631 Druid Hill Ave.

MAY 6 1947 Date rec'd by Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 1947, at 11:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to April 29 1947.
and that I last saw h alive on April 29 1947.

Immediate cause of death: Cerebral Thrombosis -
Due to Arterio-Sclerotic Heart
Disease
Due to Hypertension
Other Conditions Myocardial
Nephritis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. W. Bridgman
Address 11 E. Chase St. Date signed 5/7/47

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51398

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G51398 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1410 Mowlock St
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 56

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1410 Mowlock St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Mary Larkins

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Col
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Albert Larkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 23 - 1890

8. AGE: Years 56 Months 8 Days 13 If less than one day hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name William Underdue
13. Birthplace Richmond, Va

MOTHER
14. Maiden Name Caroline Pierce
15. Birthplace Hagerstown, Md

16 (a) Informant Henry Larkins
(b) Address 1410 N. Mowlock St

17 (a) Burial (b) Date thereof May 8, 1947 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Wm. George A. Holland
(b) Address 1629 Druid Hill Ave

19 (a) MAY 6 - 1947 (Date rec'd by registrar) (b) Huntingtor Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-5-1947 at 2:45 pm M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-2-1947 to 5/5 1947 and that I last saw h alive on 5/4 1947

Immediate cause of death

	Duration
(a) Cerebral Hemorrhage	1 week
Due to (b) Hypertension	1 day
Due to (c) Failure	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. C. Jackson
Address 1409 Mowlock St Date signed 5/6/47

VS 150

READ WITH CARE, WITH SPREADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

Batch

G51399 BOH B-69753

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓9

Registered No. G51399

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address S
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4111 Kirkway Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Gatch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1947

8. AGE: Years | Months 3 | Days 3 | If less than one day ___hr. ___min.

9. Birthplace Baltimore, Baltimore Co. Md.
(Town, county, and state)

10. Usual Occupation child.

11. Industry or business

FATHER
12. Name Charles Gatch.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Miller
15. Birthplace Fairmont, West Virginia.

16 (a) Informant Mother.
(b) Address 4111 Kirkway Ave. Balto., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 7, 1947 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Md.

18 (a) Funeral director Lazazon Funeral Home
(b) Address 2401 Belair Rd Huntington Williams, Md.

19 (a) MAY 6 1947 (b) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/5/ 1947, at 11:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/5/ 1947 to 5/5/ 1947, and that I last saw him alive on 5/5/ 1947.

	Duration
Immediate cause of death Respiratory failure	
Due to meningitis	
Due to pneumococcus -	
Other Conditions Pneumonia, pertussis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature P. Hansen

Address Sydenham Hospital Date signed M 5 D 5/47

81a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51100

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G51100

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.O.H.
(c) Hospital or institution: Henry Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1045 Front St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Susie

6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 91 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Henry Robinson Sr

13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Bennett?

15. Birthplace Balto. Md

16 (a) Informant Susie Robinson

(b) Address 1045 Front St.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 5-7-47 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location A. A. Co.

18 (a) Funeral director Byron & Mamie Wright

(b) Address 72 Aisquith St.

19 (a) MAY 6 - 1947 (Date rec'd by registrar) Washington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-7 1947, at 8:45 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH A. Fracture of L. C-V

Due to Accident

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 5-8-47

VS 151

G51401

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193D

G51401 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1008 Ridgely St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1008 Ridgely St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** WILLIAM. H-CARLISLE.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-05-8186

4. Sex MALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced. WIDOWER

6 (b) Name of husband or wife ELLEN. M. CARLISLE

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) JAN 8 1884

8. AGE: Years 63 | Months 3 2 | Days 26 | If less than one day hr. min.

9. Birthplace MD.
(Town, county, and state)

10. Usual Occupation Glass BLOWER

11. Industry or business SWINDLE BROS

FATHER 12. Name WILLIAM H CARLISLE

13. Birthplace VA.

MOTHER 14. Maiden Name MARY. MORAN

15. Birthplace MASS

16 (a) Informant MISS KATHRYN CARLISLE

(b) Address 1008 RIDGELY ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAY. 7-47 (month) (day) (year)

(c) Cemetery or crematory LOUDON PARK

Location BALTO MD

18 (a) Funeral director Bernard C Hale

(b) Address 121 E WEST ST

19 (a) 6 1947 (Date rec'd by registrar) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 4 1947; at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 26 1947 to May 4th 1947. and that I last saw him alive on May 4th 1947.

Immediate cause of death Bronchio-Pneumonia — Duration 4 days

Due to Myocarditis — 5 yrs

Due to Arteriosclerosis — 7 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature

Address 617 Scott St Date signed 5/5/47

X

G51102

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 16

G51102 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1025 Rutland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1/4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1025 Rutland Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Woodrow Benjamin Roberts

3 (b) If veteran, name war

3 (c) Social Security Account No. 232-07-9721

4. Sex: male | 5. Color or race: colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5, 1918

8. AGE: Years 29 | Months - | Days - | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Bell Hop

11. Industry or business

FATHER 12. Name Frank Benjamin Roberts

13. Birthplace Maryland

MOTHER 14. Maiden Name Mary Roberts

15. Birthplace Maryland

16 (a) Informant Mary Roberts

(b) Address 1025 Rutland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/7/1947 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem Park

Location Baltimore

18 (a) Funeral director Latty, Grace

(b) Address 1408 Ashland Ave

6 (a) 1947 (b) Washington Williams
VS 3 (Filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1947, at 9:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946 to May 5 1947 and that I last saw h[illegible] alive on May 4 1947.

Immediate cause of death	Duration
Necrosis of Thoracic Vertebrae	1 yr.
Due to Pressure on Spinal Cord	
Due to Intervertebral Spinal Column.	
Other Conditions Multiple Lung Abscess	2 yrs.
Incontinence of Bladder & Rectum	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: No

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ralph J. Young

Address 1429 E Monument Date signed 6/5/47

X

G51103 BALTIMORE CITY HEALTH DEPARTMENT G51103
Registered No.

CERTIFICATE OF DEATH 927

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 417 N. Stricker St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 417 N. Stricker St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ellen Butler

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	Widow

6 (b) Name of husband or wife James Butler
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1863

8. AGE: Years	Months	Days	If less than one day
84			hr. min.

9. Birthplace Howard Co., Md.. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name unknown
13. Birthplace Md..

MOTHER 14. Maiden Name unknown
15. Birthplace Md..

16 (a) Informant Joseph Evans.
(b) Address 1833 Druid Hill Ave

17 (a) Burial (b) Date thereof May 6, 1947 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory
Location Mt Auburn

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St
(a) 6 MAY 1947 Huntington Williams
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 1947, at 6 32 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1942, to May 2 1947, and that I last saw her alive on May 2 1947.

Immediate cause of death	Duration
Chronic Valvular Heart Disease	5 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. Wellman Frey M.D.
Address 1928 Penna Ave Date signed 5/6/47

X

G51104

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G51104

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1739 S. Charles St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1739 S. Charles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT L. SCHWEITZER

3 (b) If veteran, name war: none

3 (c) Social Security Account No. ?

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary E. Schweitzer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 15, 1866

8. AGE: Years 80 | Months 4 | Days 19 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mr. Robert E. Schweitzer
(b) Address 1723 S. Charles St. 30

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/6/47 (month) (day) (year)
(c) Cemetery Mt. Olivet Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17

19 (a) MAY 6 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 4 1947 to - 5/3 1947 and that I last saw him alive on Feb 3 1947

Immediate cause of death: Edema Bronchitis — Duration 6 mos

Due to: Arterial Hypertension — 6 mos

Due to: Arterial Sclerosis — 15 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Dead

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. B. Wheeler M.D.
Address 1779 Williams St. Date signed 5/6/47

V2 150

X

BALTIMORE CITY HEALTH DEPARTMENT

G51105 B-62695 CERTIFICATE OF DEATH 119a Registered No. G51105

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16d.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Lansdowne (If outside city or town limits, write RURAL and give town)
(d) Street No. 2930 Charleston Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Charles B E Girk ✓ Baby Charles B. Gerk

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 20, 1946

8. AGE: Years 0 | Months 5 | Days 14 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles E. Gerk
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elmira Kogler
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Charles E. Gerk
(b) Address 2930 Charleston Ave. Lansdown 27

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/7/47 (month) (day) (year)
(c) Cemetery or CREMATORY New Cathedral Cem.
Location Balto. Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17

19 (Date rec'd by registrar) MAY 6 - 1947 Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4, 1947, at 9:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 18 1947 to May 4 1947 and that I last saw him alive on May 4, 1947.

Immediate cause of death Anuria — Duration

Due to Atelectasis

Due to Aspiration of Vomitus

Other Conditions Diarrhea, Malnutrition, Dehydration
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Bruce Bonfield M. D.
Address Belvedere Hotel Date signed 5-7-47

VS 150

PLEASE WRITE CLEARLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

051106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. 051106

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison Ave. & Linden Ave.
(c) Hospital or institution: Maryland General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State ____ (b) County ____
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 410 N. Fairmount Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ____

3 (a) FULL NAME Katherine Elliott — KATHERINE SCHMIDT ELLIOTT

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Unknown
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Feb 1878

8. AGE: Years: 69 | Months: 3 | Days: 3 | If less than one day: ____ hr. ____ min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business: ____

FATHER
12. Name: Ernest Schmidt
13. Birthplace: Germany

MOTHER
14. Maiden Name: Elizabeth Senge
15. Birthplace: Baltimore, Md

16 (a) Informant: Mr. Chas. Schmidt
(b) Address: Carey & Laurens Sts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/7/47 (month) (day) (year)
(c) Cemetery: Druid Ridge Cem.
Location: Balto. Co., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS INC.
(b) Address: Baltimore 17 Md. North & Pa. Aves

19 MAY 6 - 1947 (Date rec'd by) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 May 1947, at 8:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10 Apr 1947, to 5 May 1947, and that I last saw her alive on 5 May 1947.

	Duration
Immediate cause of death: Cerebral Hemorrhage	1 hr
Due to: Hypertensive Cardio-Vascular Disease	10 yrs?
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation: ____
Major findings of operation: ____
of autopsy: ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: ____
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? ____
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____
(Specify type of place)
(e) Means of injury: ____

23. Signature: A. Allan Spicer
Address: Md Gen. Hosp. Date signed: 5 May 47

VS 150

X

DReechio

G51107

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G51107

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 Eutaw Place
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1102 Granby St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary R. DReechio

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Nicholas DReechio

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 9 1891

8. AGE: Years	Months	Days	If less than one day
55.	5	25	hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name
13. Birthplace Italy

MOTHER
14. Maiden Name Victoria Occhiao
15. Birthplace Italy

16 (a) Informant Romuald DReechio

(b) Address 102 N. Bentalou St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/7/47 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Road

18 (a) Funeral director Wendell Funeral

(b) Address 312 N. Highland Ave

MAY 6 - 1947 Huntingtown Williamsport Md.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH [illegible] 3 1947, at 9 M

21. I certify that death occurred on the date above stated, that I attended deceased from May 1947 to May 3 1947 and that I last saw h[illegible] alive on [illegible] 1947

Immediate cause of death Coronary Thrombosis — Duration

Due to Myocardial Infarction

Due to

Other Conditions Chronic Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Abraham Sabapen M. D.

Address 2028 Eutaw Pl. Date signed 5/5/47

VS 150

X

G51408

4195 69

BALTIMORE CITY [redacted] DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH 30D

Registered No. G51408

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State N.J. (b) County.....
(c) City or town Jersey City. (If outside city or town limits, write RURAL and give town)
(d) Street No. 38 Oak St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Hammond G. Pope

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	colord	married

6 (b) Name of husband or wife Eula Pope
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 5-2-87

8. AGE: Years	Months	Days	If less than one day
60	-	4	..... hr. ..... min.

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation Minister
11. Industry or business

FATHER
12. Name Henry Pope ?
13. Birthplace N. C. ?

MOTHER
14. Maiden Name Unknown ?
15. Birthplace N. C. ?

16 (a) Informant Eula G. Pope
(b) Address 3 [illegible] Johns Hopkins Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 10, 1947 (month) (day) (year)
(c) Cemetery or crematory Lincoln
Location Jersey City, N.J.

18 (a) Funeral director Wm. E. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) MAY 6 - 1947 (Date received by registrar) (b) Huntington Williams, M.D. Address [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May - 6 - 1947, at 4 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-22-1947 to 5-6-1947 and that I last saw him alive on 5-6-1947.

	Duration
Immediate cause of death Ruptured dissecting aneurysm of aorta	
Due to Arteriosclerosis	2 wks. ?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
of autopsy: Dr. Abell

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....(Specify type of place)
(e) Means of injury.....

23. Signature [illegible]
Address [illegible] Date signed M 5 D 6/47

X

Please write plainly, with unfading ink. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51109

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G51109

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 403 Lyman avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 403 Lyman avenue (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES B. HARTMAN

3 (b) If veteran, name war: World War #2
3 (c) Social Security Account No. 215-01-5300

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Florence Foster Hartman
6 (c) If alive, give age: 45 years
7. Birth date of deceased (mo., day, yr.): June 8, 1901

8. AGE: Years 45 | Months 10 | Days 26 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: Clerk
11. Industry or business:

FATHER
12. Name: Isaac Hartman
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Volear Davis
15. Birthplace: Maryland

16 (a) Informant: George F. Hartman
(b) Address: 1409 John street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/7/47 (month) (day) (year)
(c) Cemetery or crematory: Cathedral
Location:

18 (a) Funeral director: Chas. J. Evans & Son Inc.
(b) Address: 118 W. Mt. Royal Ave

19 (c) MAY 6 - 1947 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1947, at 4 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-7 1947 to 5-3 1947.
That I last saw h[er] alive on 5-3-1947

Immediate cause of death: Coronary Artery Dis.
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy:

Duration
1 mo.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify one of these) While at work?
(e) Means of injury:
23. Signature: Louis F. Cargo Jr. M. D.
Address: Date signed

VS 150

C51110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C51110

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Pimlico, Maryland
(c) Hospital or institution: Pimlico Race Track
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and name township)
(d) Street No. 1205 John Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Walter A. Norris

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 578-09-9393

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Helen Brown Norris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 27, 1897

8. AGE: Years 49 | Months 11 | Days 6 | If less than one day ....hr. ....min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Salesman

11. Industry or business: Globe Venetian Blind Co.

FATHER
12. Name: William D. Norris, Sr.
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Annie M. Huster
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mrs. Helen E. Norris
(b) Address: 1205 John street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/7/47 (month) (day) (year)
(c) Cemetery or crematory: Cathedral
Location

18 (a) Funeral director: Chas J. Evans & Son Inc.
(b) Address: 118 N. Mt. Royal Ave

19 (a) Filed MAY 6 1947 (b) By [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3rd 1947, at 3.05 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William E. Nelson M.D. Medical Examiner.
Date signed May 3 1947

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G51111

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ X 927

Registered No. G51111

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 7

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 118 Dunkirk Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Miss Anna Lavinia Donohue

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (d) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 18 1876

8. AGE: Years	Months	Days	If less than one day
71	3	17	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Retired Teacher

11. Industry or business

FATHER — 12. Name Steven Donahue

13. Birthplace Ireland

MOTHER — 14. Maiden Name Annie Stephens

15. Birthplace Ireland

16 (a) Informant Miss L G Donahue (Sis in Law)

(b) Address 118 Dunkirk Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/8/47 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore, Md.

18 (a) Funeral director H. H. Mears and Son

(b) Address 805 N. Calvert St Huntingtown Williams, Md

19 (a) MAY 6 - 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-5- 1947, at 3:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-7- 1947 to 5-5- 1947, and that I last saw h[illegible] alive on 5-4 1947

Immediate cause of death Arteriosclerosis Cer. Hem. Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.

Address [illegible] Date signed 5/5/47

FURNISH WHITE PLANNED, WITH UNIFORM RING. ENTER name of informant above of carefully supplied. Write the causes of death clearly and legibly. correct age is especially important. Physicians: please write th

VS 150

X

G51111 Bx-109041

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G51112

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 11-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 24-
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
2 City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Knights of Colombus Hotel
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard I. Harman

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Annie V. Harman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Septe.ber 14.1866

8. AGE: Years	Months	Days	If less than one day
80	7	20	hr. min.

9. Birthplace Dorset-Maryland
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Md. Unemployment Comp.Bd.

FATHER
12. Name Amos Harman
13. Birthplace Maryland (A. A. Co.)

MOTHER
14. Maiden Name Frances Ijams
15. Birthplace Maryland (A. A. Co.)

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Cremation (b) Date thereof 4/7/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Crematory
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 MAY 6 - 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1947, at 9:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 10 1947, to May 4 1947, and that I last saw h im alive on May 4 1947.

Immediate cause of death	Duration
Bronchopneumonia	3 days
Due to Arteriosclerotic C V D	yrs.
Due to	
Other Conditions Genl Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: no Post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Edmund S. Reaclam M. D.
Address Balto City Hosp Date signed 5 May 47

PRINCE WHITE PRINTING, WITH OFFSET INK.

Every item of information should be carefully supplied. Use black ink or indelible pencil, write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

VS 150

G51113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 93e

Registered No. G51113

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1002 N. Payson St.
(c) Hospital or institution:
16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1002 N. Payson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LILLIAN M. LAY

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	217-01-2918

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 13, 1899

8. AGE: Years	Months	Days	If less than one day
47	6	21	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Jacob Lay
13. Birthplace Md.

MOTHER
14. Maiden Name Barbara Kramer
15. Birthplace Md.

16 (a) Informant Mrs A.M. Kegle
(b) Address 1002 N Payson St

17 (a) Burial (b) Date thereof 5/7/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAY 6 — 1947 (b) Registrar's signature Washington Wilkinson, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4, 1947, at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 3 1947 to 1947
and that I last saw h[illegible] alive on May 4 1947

Immediate cause of death	Duration
Cerebral Thrombosis	6 hours
Due to Hypertensive Cardio-Vascular Disease; Chronic Nephritis	2½ yrs.
Due to Heart Disease.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Philip F. Lerner M. D.
Address 2901 W. North Ave. Date signed 5/6/47

VS 150

Every item of information should be carefully supplied. Where unknown, write "unknown." Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

Roost. 4.

G51114

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1830

Registered No. G51114

PLEASE WHITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Oliver & Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos. or days) 8 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3603 Southern Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert J. Reilly.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Margaret Reilly.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 1 - 1871

8. AGE: Years 75 | Months 5 | Days 4 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name ?
13. Birthplace ?

MOTHER 14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Margaret Reilly
(b) Address 3603 Southern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/7/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Balto

18 (a) Funeral director J. J. Luck
(b) Address 5305 Harford Road

MAY 6 - 1947 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1947, at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 28 to 47. to May 5, 1947. and that I last saw him, alive on April 5, 1947.

Immediate cause of death: Cardio-respiratory failure. — Duration

Due to: Arterial Sclerosis.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gregory M. Harrison
Address Johns Hopkins Hosp. Date signed 5/5/47

VS 150

G51115

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G51115 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1350 Crofton Rd
(c) Hospital or institution: No
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 year

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1350 Crofton Rd (If rural, give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME Frank E. Reader

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	~~Widowed~~

6 (b) Name of husband or wife late Jennie Neubert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12 · 15 · 1868

8. AGE: Years	Months	Days	If less than one day
78	4	20	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Frank S. Reader

13. Birthplace Penna

MOTHER 14. Maiden Name Meran Darling

15. Birthplace N. Y.

16 (a) Informant Miss Meran E. Reader

(b) Address 1350 Crofton Rd

17 (a) Removal (b) Date thereof 5 · 6 · 47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location New Brighton Penna.

18 (a) Funeral director Harry A. Wetzke

(b) Address 4101 E. Lafayette Ave.

19 (a) MAY 6 - 1947 Filed Wilmington, Mass.
(Must not be filled in by registrant)

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1947 at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1946 to May 5 1947, and that I last saw h[illegible] alive on May 5 1947

Immediate cause of death	Duration
Pneumonia terminal	3 days
Due to Dehydration, inanition	5 days
Due to Arthritis, deformans multiple sprue	1940
Other Conditions senile degeneration arteriosclerosis, cerebral hemorrhage	Dec 46

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

PHYSICIAN Jan 1947

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank R. Smith, Jr.

Address 10 145 St Paul St. Date signed 5/6/47

59 B

G51116

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G51116

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green St.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Frederick
(c) City or town Frederick
(If outside city or town limits, write RURAL and give town)
(d) Street No. Frederick, Md
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roy W. Cutsail III

3 (b) If veteran, name war None

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/1945

8. AGE: Years 1 | Months 6/8 | Days | If less than one day ... hr. ... min.

9. Birthplace Frederick, MD.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Roy W. Cutsail, Jr
13. Birthplace Frederick, MD.

MOTHER
14. Maiden Name Evelyn R. Dutrow
15. Birthplace Frederick Co. MD.

16 (a) Informant Roy W. Cutsail, Jr
(b) Address Wilson Ave; Fred'k, MD

17 (a) Burial (b) Date thereof 5-8-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick, MD.

18 (a) Funeral director M.R. Etchison & Son
(b) Address Frederick, MD.

19 MAY 6 - 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-6 1947 at 12 15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-8-47 1947 to 5-6 1947 and that I last saw h.[illegible] alive on 5-6 1947.

Immediate cause of death Acute glomerulonephritis with nephrotic syndrome. — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gerald A. Martin M. D.
Address University Hospital Date signed 5-6-47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51117

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 83a

Registered No. G51117

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Sykesville (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Roy T. Buckingham

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-12-9502

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Winnifred Daley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14 1890

8. AGE: Years	Months	Days	If less than one day
56 57	9	23 25	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Thomas Buckingham
13. Birthplace Md.

MOTHER
14. Maiden Name Louisa Depp
15. Birthplace Md.

16 (a) Informant Mrs. George Beamon
(b) Address Finksburg, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-8-47 (month) (day) (year)
(c) Cemetery or crematory Freedom Cemetery
Location Mt. Sykesville, Md.

18 (a) Funeral director C. Harry Weis
(b) Address Sykesville, Md.

19 (a) 5-6-1947 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1947 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-28 1947 to 5-5 1947 and that I last saw h[illegible] alive on 5-5 1947.

Immediate cause of death Cardiac failure Duration
Edema of Lungs
Cerebral Edema

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. W. Munk M. D.
Address Sykesville Date signed 5/5/47

X

G51118 G51118

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 462

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1411 Hull St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1411 Hull St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Theodore Swirdowich

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NO

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife LENORA Swirdowich
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1861

8. AGE: Years	Months	Days	If less than one day
85	7		hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Retired Stevedore
11. Industry or business

FATHER
12. Name Michael Swirdowich
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Walter Swirdowich
(b) Address 1411 Hull St.

17 (a) Burial (b) Date thereof 5/9/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Trinity Cem.
Location A.A. County

18 (a) Funeral director Charles F. Dill
(b) Address 1501 E. Fort Ave

19 (a) 1947 Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 1947, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 12, 1947 to May 6 1947 and that I last saw him alive on May 1, 1947.

Immediate cause of death: Coronary Thrombosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. A. Friedman, M.D.
Address 1319 Eutaw St. Date signed May 6 1947

VS 150

651119

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 47c

Registered No. 651119

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 38 days
(e) Length of stay in Baltimore (yrs., mos., or days): 38 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Wis. (b) County:
(c) City or town: Milwaukee
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 1575 W. Beecher St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: Cieciera, George John

3 (b) If veteran, name war:
3 (c) Social Security Account No.: 134-05-3932

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widower

6 (b) Name of husband or wife: Angela ?
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 17, 1894

8. AGE: Years	Months	Days	If less than one day
53	3	15	hr. min.

9. Birthplace: Poland (town, county, and state)
10. Usual Occupation: Fireman
11. Industry or business: Seafarer

FATHER
12. Name: Casimir Cieciera
13. Birthplace: Poland

MOTHER
14. Maiden Name: Margaret ?
15. Birthplace: Poland

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-7-47 (month) (day) (year)
(c) Cemetery or crematory: Forest Cemetery
Location: York Road
18 (a) Funeral director: Wm. H. Wolfinger Funeral Home Inc.
(b) Address: 403-E-25th St.
19 MAY 7 - 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 2 1947 at 10:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 25 1947 to May 2 1947 and that I last saw h. in alive on May 2 1947

Immediate cause of death: Carcinoma, bronchogenic, right lung with metastasis to 7th cervical vertebra and liver — Duration: UNKNOWN

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Virgil J. Dorset, Surgeon
Address: US Marine Hospital, Balto, Md. Date signed 5/5/47

VS 180

G51120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G51120

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hyman Pk. Drive & 31st Sts.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State DC (b) County
(c) City or town Washington
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1533 Pennsylvania Ave. SE
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Redin, Charles Wesley

3 (b) If veteran, name war: WWI

3 (c) Social Security Account No. 526-05-3129

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife: Lavalette Holmes
6 (c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): Jan. 29, 1891

8. AGE: Years	Months	Days	If less than one day
56	3	6 7	hr. min.

9. Birthplace: Dubois, Pa.
(Town, county, and state)
10. Usual Occupation: Waiter
11. Industry or business:

FATHER
12. Name: Charles W. Redin
13. Birthplace: Pa.

MOTHER
14. Maiden Name: Margaret Wilson
15. Birthplace: Pa.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) [redacted] Removal Date thereof 5-8-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory: Arlington Nat. Cemetery
Location: Fort Myer - Va.

18 (a) Funeral Director: Wright & Weedon Funeral Home Inc.
(b) Address: 403-E-25 E St.

MAY 7 - 1947 (Date received by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 5 1947, at 7:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 5 1947 to May 5 1947 and that I last saw h im alive on May 5 1947

Immediate cause of death: Coronary sclerosis with occlusion — Duration: UNKNOWN

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon M.D.
Address Clinical Director Date signed 5/8/47

VS 150

G51121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G51121

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden and Madeira Sts
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1818 Whitelock Ave # 16
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Dorzon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Female	White	Married

6 (b) Name of husband ~~or wife~~ John Thomas Dorzon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 3rd 1872

8. AGE: Years	Months	Days	If less than one day
74	8	3	hr. min.

9. Birthplace K & Q Co Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Thomas Lawson
13. Birthplace Va

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Paul Dorzon
(b) Address 1818 Whitelock Ave

17 (a) Burial (b) Date thereof 5/9/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Balto. Co. Md.

18 (a) Funeral director Williams Cook Inc
(b) Address 27 St. Paul St

19 (c) Date received MAY 7 1947 (Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6th 1947, at 4:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/30/1947 to 5/6/1947 and that I last saw h~~er~~ alive on 5/7/1947.

Immediate cause of death	Duration
Heart failure	
A.C.V. Uremia & Convulsions	
~~Due to~~ fibrillation,	36 days.
Due to Gangrene & Septicemia	
Other conditions Due uncontrolled diabetes mellitus	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. E. Gonzalez
Address Maryland Gen. Hospital Date signed 5/7/47

G51122

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G51122

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2819 Eastern Avenue
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2819 Eastern Avenue (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country no

3 (a) FULL NAME Joseph Serra

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Guglemia
no
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25, 1861

8. AGE: Years	Months	Days	If less than one day
86	1	11	hr. min.

9. Birthplace Carrara, Italy (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Andrew Serra
13. Birthplace Italy

MOTHER
14. Maiden Name Maria Unknown
15. Birthplace Italy

16 (a) Informant William J. Serra
(b) Address 2819 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 9-47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cemetery
Location Baltimore

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 127 St. Paul Street

19 (a) MAY 7 - 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1947, at 11:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1, 1947 to May 5 1947, and that I last saw him alive on May 5 1947.

Immediate cause of death	Duration
Hypostatic Congestion Vascular Disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Andrew Hunsworth M. D.
Address 2529 Eastern av. Date signed

X

5I123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163 H

Registered No. G5I123

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2610 Rittenhouse Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2610 Rittenhouse Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian C. Bealefeld.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife John B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1900

8. AGE: Years	Months	Days	If less than one day
46	9	21	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name George Block
13. Birthplace Peoria, Ill.

MOTHER
14. Maiden Name Katherine Ruehle
15. Birthplace Germany

16 (a) Informant Louise B. Hall
(b) Address 2613- Rittenhouse Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 8 1947 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A. A. Co. Md.

18 (a) Funeral director Mr. Mrs. John W. Teufel & Son
(b) Address 5311 Edmondson Ave.

19 (a) MAY 7 1947 (Date received by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5, 1947 at 10 a M

21. I certify that I took charge of the remains described above, held an insp. & inq. thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Illuminating gas.

Other Conditions Despondency.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-5-47 at 9 a. M.
(b) Where did injury occur? 2610 Rittenhouse Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Oven + 4 burners of gas range open & unlit.

23. Signature Howard J. Mendelsio M.D. Medical Examiner.
Date signed 5-5-47

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51124

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G51124

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3516 Lucille Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 34 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4724 Delaware Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leah Cohen

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Max
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years	Months	Days	If less than one day
59			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name unknown
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Max Cohen
(b) Address 4724 Delaware Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-7-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phila Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1459 E Baltimore St

MAY 7 - 1947 (Date rec'd by registrar) Huntington Williams MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-6- 1947, at 3P 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945 to May 6 1947, and that I last saw him alive on May 6 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	4m
Due to	
Due to	over
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
Surface cell carcinoma
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. B. Leonard M.D.
Address 1901 Eutaw Pl Date signed 5/6/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Type correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G51125

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT AND SARATOGA
(c) Hospital or institution:
MERCY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) 21 DAYS

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Prince George
(c) City or town MT. RANIER.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3702 - 36 St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CELIA RUBIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	WIDOWED

6 (b) Name of husband or wife Lorcin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886? JULY?

8. AGE: Years	Months	Days	If less than one day
60?	10		hr. min.

9. Birthplace HUNGARY
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name LAZAR GROSS
13. Birthplace HUNGARY

MOTHER
14. Maiden Name REGINA HERKOWITZ
15. Birthplace HUNGARY

16 (a) Informant Lawrence Lubin
(b) Address 3702-36st Mt Rainer Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-7-47 (month) (day) (year)

(c) Cemetery or crematory United Hebrew
Location Wrightwood Boulevard

18 (a) Funeral director Jack Lewis Inc
(b) Address 419 E. Balto St

(Signature) Huntington Williams, M.D. Registrar

MAY 7 - 1947
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-6 1947, at 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-15 1946 to 5-6 1947. and that I last saw her alive on 5-6 1947

Immediate cause of death RESPIRATORY FAILURE — Duration

Due to UREMIA

Due to ARTERIOSCLEROTIC KIDNEY

Other Conditions HYPERTENSION GENERAL ARTERIOSCLEROSIS
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James A. Roberts M. D.
Address Mercy Hospital Date signed 5-6-47

651126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 651126

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 132 Lafayette Avenue
(c) Hospital or institution:
Nursing Home
app.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 103 W. Monument St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) NO
If yes, name country

3 (a) FULL NAME SUSAN DOBBIN LEAKIN

3 (b) If veteran, name war: NONE
3 (c) Social Security Account No.: NONE

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: **********
6 (c) If alive, give age ** years

7. Birth date of deceased (mo., day, yr.) ? about 1861

8. AGE: Years: about - 86 | Months: ? | Days: ? | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation: NONE
11. Industry or business: NONE

FATHER
12. Name: Sheperd A. Leakin
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Isabella George Wilson
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mr. Andrew J. YOung, Jr.
(b) Address: 34 Central Savings Bank, City.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May-7-1947 (month) (day) (year)
(c) Cemetery or crematory: Green Mount
Location: Baltimore, Maryland

18 (a) Funeral director: Stewart & Mowen Company
(b) Address: 106 West North Avenue, Balto. Md.

MAY 7 - 1947 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1947, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1935 to May 5 1947 and that I last saw h alive on May 5 1947

Immediate cause of death: Multiple Sclerosis
Due to: Myocarditis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration: Gradual

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:
23. Signature: H H Leaky
Address: 1403 Park Ave. Date signed: 5/6/47

VS 150

1127

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 651127 / 107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 min
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 203 Camel St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Florine Burgess

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 3, 1938

8. AGE: Years	Months	Days	If less than one day
9	4	1	hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation child
11. Industry or business

FATHER
12. Name Joshua Burgess
13. Birthplace South Carolina

MOTHER
14. Maiden Name Odessa Brown
15. Birthplace North Carolina

16 (a) Informant Joshua Burgess
(b) Address 203 Camel St

17 (a) Burial (b) Date thereof May 8 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemet.
Location Cedar Hill Md.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

MAY 7 - 1947 Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1947, at 12:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to.....

Other Conditions Acute mesenteric adenitis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Earl L. Ryan M.D.
Medical Examiner.
Date signed.....

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G51128 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 523 N. Clinton St.,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 523 N. Clinton St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET BESOLD-[redacted]

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Rudolf Besold
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24, 1864

8. AGE: Years	Months	Days	If less than one day
82 yrs.	10	11	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

MOTHER, FATHER
12. Name Simon Eggerstedt
13. Birthplace Unknown
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Minnie M. Schaefer-daughter
(b) Address 523 N. Clinton Street

17 (a) Ship (Burial, cremation, or removal) (b) Date thereof 5/7/47 (month) (day) (year)
(c) Cemetery or crematory Lutheran Cemetery
Location Jamaica, Long Island, N. Y.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

MAY 7 - 1947 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1947, at 5 A.M. P.M.

21. I certify that death occurred on the date above stated; that deceased from June 1944 to May 5 1947, and that I last saw h[illegible] alive on May 5 1947.

Immediate cause of death	Duration
ARTERIO SCLEROSIS	3 Yrs.
Due to	
Due to UREMIA	2 DAYS.
Other Conditions CAR.-INT.-VERM	3. YRS

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James F. Kenworthy M.D. M. D.
Address 701 W. Redwood St. Date signed 5-6-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be complete and correct as the certificate may be required for medico-legal purposes. Give full name of deceased. Do not use initials. Give usual residence. Do not omit the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

52-129

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G51129

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 413 Grenton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 413 Grenton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John R. Christopher
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 22, 1866

8. AGE: Years 81 | Months 3 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Aquila B. Christopher
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name ~
15. Birthplace ~

16 (a) Informant Mr. Frank Christopher
(b) Address 413 Grenton ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/8/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location 4430 Belair Road

18 (a) Funeral director Harry W. Blight Jr.
(b) Address 4914 Belair Road

MAY 7 1947 (Date Rec'd by Registrar) Hamilton W. Mackall M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/6 1947, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/11 1946, to 5/6 1947.
and that I last saw him alive on 3/7 1947.
Immediate cause of death Arteriosclerosis

Due to —

Due to

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

Duration
Undetermined

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. J. Battaglia M.D.
Address 5829 Belair Rd Date signed 5/6/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

51130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

C51130 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6109 Belair Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6109 Belair Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME A. LULIE OSBORN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife John R. Osborn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20th, 1869

8. AGE: Years	Months	Days	If less than one day
77	11	16	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Philip Greenfield
13. Birthplace Maryland

MOTHER
14. Maiden Name Susan Gordon
15. Birthplace Maryland

16 (a) Informant Mrs. Beulah Jehnert
(b) Address 6109 Belair Road

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 5/9/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location 3310 Taylor Ave.

18 (a) Funeral director Lasuchin Funeral Home
(b) Address 7401 Belair Road.

19 (a) MAY 7 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6th 19 47 at 11:59 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to April 1947 and that I last saw her alive on April 26 1947.

Immediate cause of death Cardiac failure — Duration

Due to Coronary Thrombosis — Duration

Due to — Duration

Other Conditions Parkinson's Disease — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan
Address 5217 Harford Road Date signed M. 5 D. 6 47

X

51131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. C51131

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3319 Belvedere Ave.
(c) Hospital or institution: W

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3319 Belvedere Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Helen D. Trainor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife John A. Trainor
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) March 9, 1894

8. AGE: Years	Months	Days	If less than one day
53	1	24	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Breitlauft
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant John A. Trainor
(b) Address 3319 Belvedere Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/14/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Martin Fahey & Sons
(b) Address 1827 W. North Ave.

19 (a) MAY 7 1947 (Registrar) (b) Burlington for Williamsville

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 1947, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947, to May 3 1947, and that I last saw h[illegible] alive on May 3 1947

Immediate cause of death Uraemia
Obstruction to Bowels
Due to Probable Carcinoma of Bowel
Due to Chronic Orthritis
Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation no
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Johnston J. Wells
Address 5276 Park Heights Date signed May 5 47 M.D.

651132

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

651132 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1620 Hollins St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 Hollins St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Bascom Roberts

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widow

6 (b) Name of husband or wife Ella May Barber
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19, 1864

8. AGE: Years	Months	Days	If less than one day
82	11	17	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name John B. Roberts
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary Ann Burns
15. Birthplace Balto. Md.

16 (a) Informant Charles K. Roberts
(b) Address 303 Dan Sant Ave. Linwood, N.J.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/8/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director John O. Mitchell Funeral Dir.
(b) Address 1900 Eutaw Place

MAY 7 - 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6, 1947, at 6 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 13 1946 to May 6 1947, and that I last saw him alive on May 5, 1947

Immediate cause of death: Duration
Pneumonia
Due to
Due to
Other Conditions Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William Kraemer M. D.
Address 1429 W. Fayette St. Date signed

X

G51433 Raleigh TAYLOR G51433

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45F

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 120 W 21st St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 120 W-21st St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Raleigh Taylor

3 (b) If veteran, name war: World's War I
3 (c) Social Security Account No. 216-03-6650
4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Seperated
6 (b) Name of husband or wife:
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 2-1893
8. AGE: Years 54 Months 10 Days 28 If less than one day hr. min.
9. Birthplace Charlesville Va (Town, county, and state)
10. Usual Occupation Cook
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Luckenam
15. Birthplace

16 (a) Informant John Whitakey
(b) Address 120 W-21st St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 7-47 (month) (day) (year)
(c) Cemetery or crematory Balto Nat. Cmetery
Location Frederick Road
18 (a) Funeral director Va Brooks
(b) Address 1463 N. Carey St
19 (a) 5/7/47 (Filed by registrar) (b) Huntington Williams, M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-30-47 19 , at 7 3/4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-12 19 47 to 4-30 19 47 and that I last saw h[illegible] alive on 4-29-47 19

Immediate cause of death: Coronary Thrombosis — Duration 2

Due to:

Due to:

Other Conditions: Hypertension
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. Clyde Edmunds, M. D.
Address 238 N Carey St Date signed 5-5-47

X

51134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G51134 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Emerson Ave & B.
(c) If hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Emerson Ave & B. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME RACHEL OTTENHEIMER BERGEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband ~~or wife~~ Joseph Bergen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1861

8. AGE: Years	Months	Days	If less than one day
85 84	11	27	hr. min.

9. Birthplace Balto, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Moses Ottenheimer
13. Birthplace Germany

MOTHER
14. Maiden Name Bettie Cohen
15. Birthplace Balto. Md.

16 (a) Informant Mrs. I. Kaufman
(b) Address Emerson Ave & B.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/9/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Ohel Shalom
Location Balto, Md.

18 (a) Funeral director Sinai Memorial Chapel
(b) Address 1702 Eutaw Place

MAY 7 - 1947 (a) Date received (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1947 at 3:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1946 to May 7 1947 and that I last saw ~~he/she~~ alive on May 7 1947

Immediate cause of death Coronary Occlusion — Duration 6 hours

Due to Arteriosclerotic Cardiovascular Disease — I 35 yrs

Due to

Other Conditions Hypertensive Cardio-Vascular Disease — I 30 years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Edward Levi, M.D.
Address 1107 N. Calvert St Date signed 5/9/47

VS 150

2.

651435

651435 BC# F99337

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1577

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3809 Milford Ave.
(c) Hospital or institution: Lg

(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3809 Milford Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3 (a) FULL NAME Richard Carlton Merkle

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 24 1947

8. AGE: Years	Months	Days	If less than one day
3	-	12	hr. ..... min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business .....

FATHER
12. Name Henry V. Merkle,
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Ethel T. Bowers,
15. Birthplace Balto. Md.

16 (a) Informant Mr. Henry V. Merkle
(b) Address 3809 Milford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/7/47 (month) (day) (year)
(c) Cemetery Oak Hebron
Location Balto. Md.

18 (a) Funeral director Laird Anderson & Son
(b) Address 1202 Eutaw Place

19 (a) MAY 7 1947 (b) Twitington Williams M.D.
(Date received by registrar) (Signature)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 1947, at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 19.. to .....19.., and that I last saw h.. alive on .....19..

Immediate cause of death Heart Failure — Duration .....
Due to Intracranial Pressure — Duration .....
Due to Birth Deformity Malformation of Brain — Duration .....
Other Conditions — Duration .....
(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Edmund Dorf M. D.
Address 3102 Garrison Blvd Date signed 5/6/47

G51136

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

Registered No. G51136

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4406 Wentworth Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4406 Wentworth Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Alverda Virginia Hopaley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Joshua G. Hopaley (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 29-1867

8. AGE: Years	Months	Days	If less than one day
79	4 5	5 7	hr. min.

9. Birthplace Woodsboro Maryland (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name George W. Woodward
13. Birthplace Baltimore Co. Md.

MOTHER
14. Maiden Name Sarah J. Gram
15. Birthplace Balto Co. Md.

16 (a) Informant Mrs Thomas W. Rogan
(b) Address 102 W. 39th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 8-47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.

18 (a) Funeral director Ellsworth Bryan Co.
(b) Address 3911 Liberty Heights Ave

19 MAY 8 - 1947 Lexington Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5, 1947, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 14 1947 to May 5, 1947 and that I last saw h[illegible] alive on May 1, 1947

Immediate cause of death Chr. Myocarditis — Duration

Due to Chr. Nephritis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. E. Hamm M.D.
Address 520 Medical Arts Bldg Date signed 5/7/47

X

G5I137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G5I137

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 612 Brant st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 612 Brant st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Henry Reid

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Emma Reid

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years 53 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Elijah Reid
13. Birthplace Virginia

MOTHER 14. Maiden Name unknown
15. Birthplace "

16 (a) Informant Emma Reid
(b) Address 612 Brant st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 8-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Baltimore Md.

18 (a) Funeral director Mrs Ida Bailey
(b) Address 1421 E Jefferson st

19 (a) MAY 7 1947 (Date rec'd by local registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May - 5 1947, at 3:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1 1946 to May 5 1947 and that I last saw h[illegible] alive on May 5 1947

Immediate cause of death: Cardio-Renal Disease — Duration: 6 mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis A. Johnson M. D.

Address 2329 Guilford Ave Date signed May 6 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

51138

CMK-110207

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G57138

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 76
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 70 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 313 S. Conkling Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Hentz (or William Hintz or William Heintz)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Martha
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 8-1862

8. AGE: Years	Months	Days	If less than one day
84	7	28	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John Hentz
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara ?
15. Birthplace Germany

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 5/9/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Herman Hill Road

18 (a) Funeral director Lilly & Zeller
(b) Address 403 S. Dolphin St.

MAY 7 1947
(Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH May 6 1947, at 12:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 26 1947, to May 6 1947, and that I last saw h. im alive on May 6 1947.

Immediate cause of death	Duration
Bronchopneumonia Left	3 days
Due to Arteriosclerosis C.V.D	
Auricular Fibrillation	
Due to	
Other Conditions Pulmonary Infarction	Years
from Iliac Thrombosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: as above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edmund Beadnell M. D.
Address Balto City Hosp Date signed May 6-47

X

51139
514640

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

G51139
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1720 E. Lohans St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Laura Wells (Laura J. Wells)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: George Wells

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-4-63

8. AGE: Years 83 | Months 11 | Days 1 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation At-Home

11. Industry or business

FATHER
12. Name ? ? (William J. Anderson)
13. Birthplace ? ? (Petersburg Va)

MOTHER
14. Maiden Name ? ? (Isabelle Harris)
15. Birthplace JOHNS HOPKINS HOSPITAL (Md.)

16 (a) Informant Rawonda.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/8/47 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Park
Location

18 (a) Funeral director Robert L. Gaynor & Sons
(b) Address 1216 W. Caroline St.

19 (a) Date received MAY 7 1947 (Registrar) Huntington Williams M.D.
(b) Registrar's signature per Earl L. Rogers M.D.

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH May-5 1947, at 4.05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May-4 1947 to May 5 1947, and that I last saw h[er] alive on May-5 1947.

Immediate cause of death Pulmonary Edema & anuria — Duration 24 hours

Due to Hypertension 1°, 2°, 3° Lesions (88%) — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation 0

Major findings of operation: 0

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 8/7

(a) Accident, suicide, or homicide accident

(b) Date of occurrence 5-4-47 at 12 M.

(c) Where did injury occur? Baltimore, Md. (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? (Farm not on farm)

(e) Means of injury Hanging lamp fixture

23. Signature R. N. Hamlyn M. D.

Address Johns Hopkins Hosp. Date signed 5-5-47

G5144 ~~I~~ 76123
O.K. Dr. Zahn

BALTIMORE CITY HEALTH DEPARTMENT X
CERTIFICATE OF DEATH √159

G5144 Registered No. 190

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 days

2. USUAL RESIDENCE OF DECEASED: 21761
(a) State Md (b) County Howard Co.
(c) City or town Elkridge
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Anita Ellen Pope

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-16-47

8. AGE: Years | Months | Days 8 10 | If less than one day hr. min.

9. Birthplace Bon Secours Hospital (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Andrew Sebastian Pope
13. Birthplace Hanover Maryland

MOTHER 14. Maiden Name Anita Teresa Pope
15. Birthplace Anglesea Maryland

16 (a) Informant Catherine Beretta (Aunt)
(b) Address Riley & O Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-26-47 (month) (day) (year)
(c) Cemetery or crematory St Augustine's
Location Elkridge Md

18 (a) Funeral director none employed
(b) Address

19 (a) April 26 1947 (Date rec'd by registrar) (Miss) E Bird Mallonee (Signature of registrar)

MAY-7-1947 Funeral Home Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 1947 at 12 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw h[illegible] alive on 19

Immediate cause of death Prematurity | Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter B. Sanger
Address Bon Secours Hospital Date signed 4/26/47

X

G51141

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓937

G51141 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4625 Pennington Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa Snyder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 13 1884?

8. AGE: Years 63 | Months 3 | Days 23? | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Ludwig Nagle
13. Birthplace Germany

MOTHER
14. Maiden Name Emma Funk
15. Birthplace Md

16 (a) Informant Charles S. Snyder
(b) Address 4626 Pennington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/10/47 (month) (day) (year)
(c) Cemetery or crematory Meadow Rustic
Location Wash. Blvd

18 (a) Funeral director Edward Foulson
(b) Address 2159 Wash. Blvd

MAY 7 - 1947 (Date rec'd by local registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6, 1947, at 11 05 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to R.I.P. death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil A. Beyer M.D. Medical Examiner.
Date signed 5/6/47

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G51112

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 820 N. Vincent St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 820 N. Vincent St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Leon Sampson.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race C

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Mattie Sampson,

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 8, 1903

8. AGE: Years 54 | Months 3 | Days 25 | If less than one day hr. 93 min. 1893

9. Birthplace Richmond, Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Henry Sampson

13. Birthplace Md.

MOTHER 14. Maiden Name Rebecca Stephenson

15. Birthplace Richmond, Va

16 (a) Informant Dorothy Hill (daughter)

(b) Address 4026 Reno Phila, Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 7, 1947 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial

Location

18 (a) Funeral director Mrs. Katie R. Williams

(b) Address 322 N. Schroeder St.

MAY 7 - 1947 (Date rec'd by local reg.) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/2 1947 at 4A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-27 1947 to 5/2 1947 and that I last saw h— alive on 5/1 1947

Immediate cause of death

Hypertensive Cardiac Renal Vascular

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature B. J. Hatcher M. D.

Address 1225 Park Ave. Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G51143 Registered No. 61

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 39 days
(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: Baltimore
(c) City or town: (If outside city or town limits, write RURAL and give town)
(d) Street No.: 442 N. Fremont Ave. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country:

3 (a) FULL NAME: Richard Pernell Turner

3 (b) If veteran, name war: WW I

3 (c) Social Security Account No.: 219-14-1490

4. Sex: M

5. Color or race: col

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 9, 1889

8. AGE: Years: 58 Months: 0 Days: 24 If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Cook

11. Industry or business: Seafarer

FATHER
12. Name: Richard Turner
13. Birthplace: Va.

MOTHER
14. Maiden Name: Ella Freely
15. Birthplace: Md.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: May 7, 1947 (month) (day) (year)
(c) Cemetery or crematory: National
Location:

18 (a) Funeral director: Mrs. Katie A. Williams
(b) Address: 322 N. Schroeder St.

MAY 7 1947 (Date of registration) Katie A. Williams, Mgr.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 5 1947, at 9:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 25 1947 to May 5 1947, and that I last saw him alive on May 5 1947.

Immediate cause of death	Duration
Bronchopneumonia	7 days
Acute cystitis with anuria	3 days
Due to: Primary carcinoma of the bladder	UNKNOWN
Due to:	
Other Conditions: Chronic glomerulonephritis; diabetes mellitus (Include pregnancy within 3 months of death)	
Date of operation:	
Major findings of operation:	
of autopsy: SAME	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Marion Friedman, MD M. D.
Address: US Marine Hospital, Balto., Md. Date signed: 5/6/47

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G51144

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G51144

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1807 W North Ave
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 W North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Esther Ruf

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col	Married

6 (b) Name of husband or wife Jeweart Ruf
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 20, 1898

8. AGE: Years	Months	Days	If less than one day
48	5	13	hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Sidney Jones
13. Birthplace Va

MOTHER
14. Maiden Name Elizabeth Bell
15. Birthplace Va.

16 (a) Informant Venerable Wilson
(b) Address 1807 W North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 7 1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Park
Location Arbutus Md

18 (a) Funeral director Mrs. Pott A. Elliott Dayne
(b) Address 1129 N. Carrolling St

19 MAY 7 - 1947 (Date rec'd by Registrar) (b) Washington Hill

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 1947 at 4P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1947 to May 3 1947.
and that I last saw h alive on May 3 1947.

Immediate cause of death	Duration
(a) Uremia Nephritis	Jan 1947
Due to Uremia	
Due to Arterio Sclerosis	
Other Conditions Medical Pneumatosis Hemorrhoid Hypertension. (Include pregnancy within 3 months of death)	

Date of operation None
Major findings of operation None
of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Ralph J. Young M. D.
Address 1429 E. Monument Date signed May 5 1947

VS 150

G51145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G51145 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount Ave.
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., ~~months or~~ days) 11
(e) Length of stay in Baltimore (yrs., ~~months or~~ days) 50

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 6916 Ridgeway Rd. (If rural give location)
(e) Citizen of foreign country? [redacted] ? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Felicia Procopio

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband ~~of wife~~ Gaspar Procopio

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1888

8. AGE: Years 58 | Months 7 8 | Days 21 | If less than one day ..... hr. ..... min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business Housework.

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown.
15. Birthplace

16 (a) Informant Mrs. Lennie Smith
(b) Address 6916 Ridgeway Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 9 1947 (month) (day) (year)
(c) Cemetery ~~xxxxxxxx~~ Mt. Carmel
Location 0 Donnell St. Baltimore Md.

18 (a) Funeral director Frank Dillon Hall
(b) Address 52 N. Morley St.

19 (a) May 7 1947 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 1947, at 1:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 25 1947, to May 6 1947, and that I last saw her alive on May 6 1947.

Immediate cause of death Acute Appendicitis — Duration 25 days.

Due to —

Due to —

Other Conditions Secondary pregnancy — 5 days.
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature David Barbach M. D.
Address — Date signed 5/10/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G5I146

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G5I146

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT AND SARATOGA
(c) Hospital or institution:
MERCY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19D.
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALT. MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1805 FREDERICK AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME JOHN J. HEALY

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife PAULINE T. HEALY
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 15, 1895

8. AGE: Years	Months	Days	If less than one day
51	9	22	hr. min.

9. Birthplace BALT. MD.
(Town, county, and state)
10. Usual Occupation UNEMPLOYED.
11. Industry or business Roofing

FATHER
12. Name JAMES T. HEALY
13. Birthplace IRELAND

MOTHER
14. Maiden Name ANNA HALFPENNY
15. Birthplace IRELAND

16 (a) Informant Pauline T. Healy
(b) Address 1805 Fredrick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/9/47 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Baltimore Md

18 (a) Funeral director Wilkins & Son
(b) Address 1214 W Fayette St.

19 (a) MAY 7 - 1947 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-6 1947, at 7:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-17 1947 to 5-6 1947 and that I last saw him alive on 5-6 1947

Immediate cause of death	Duration
RESP. FAILURE	
Due to UREMIA	
Due to ARTERIOSCLEROTIC KIDNEYS	
Other Conditions DEG. ARTERIOSCLEROSIS & HYPERTENSION	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James A. Roberts M. D.
Address Mercy Hospital Date signed 5-6-47

VS 150

X

G51147

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V92a

G51147 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital V
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2240 W. Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Busick

3 (b) If veteran, name war W

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Florence

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4. 1894

8. AGE: Years 53 | Months 0 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name George L Busick
13. Birthplace Md

MOTHER
14. Maiden Name Mary Elliott
15. Birthplace Md

16 (a) Informant Florence Busick
(b) Address 2448 W Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/9/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Fallon Funeral Home
(b) Address 1217 E Fort Ave

19 (a) MAY 7 1947 (Date received by Registrar) (b) Registrar Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/6 1947, at 8 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subdural Hemorrhage

Due to

Other Conditions Aortic stenosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Ryan M.D. (Medical Examiner)
Date signed 5-7-47

VS 181

53a

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51148

CHK-110562

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

V.13 B

G51148

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 18 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 726 Spring Street Z-5
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Neal, Alma Walker (Alma Walker Neal)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Albert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 31-1925

8. AGE: Years	Months	Days	If less than one day
22	1	23	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Samuel Walker
13. Birthplace Virginia

MOTHER
14. Maiden Name Romanda Goldsburg
15. Birthplace Virginia

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 7, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location Brooklyn Md
18 (a) Funeral director Elroy B. Wilson
(b) Address 1000 Brantley Rd

17 (a) May 7 1947 (Date received by registrar) (b) Registrar

Clayton Williams M.D.

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH May 3-1947 19 , at 7:[illegible] M

21. I certify that death occurred on the date above stated; that I attended deceased from May 2 1947 to May 3 1947, and that I last saw her alive on May 3 1947.

Immediate cause of death	Duration
Respiratory Failure	—
Due to Pulmonary Tuberculosis Unilateral, far advanced	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edmund S. Beasham M. D.
Address Balto City Hosp Date signed 4 May 47

X

G51149

G51149

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 119 N. Bond St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 119 N. Bond St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Rosa Rachel Bush

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife James Bush

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 26, 1890

8. AGE: Years 56 | Months 6 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name John Brady

13. Birthplace md

MOTHER 14. Maiden Name Lillie Barrett

15. Birthplace md

16 (a) Informant Mildred Brown

(b) Address 119 N. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 8 1947 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem.

Location Baltimore Md

18 (a) Funeral director Chas. S. Wilson

(b) Address 1700 Bentley ave

19 (a) 1947 (b) Jan Williams, M.D. Registrar

5/7/47

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1947, at 7:15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 2 1947, to May 4 1947, and that I last saw h[illegible] alive on May 2 1947.

Immediate cause of death Cerebral Hemorrhage

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul Snyder M.D.

Address 1634 E. Baltimore Date signed 5/5/47

VS 150

G51150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 47 G51150 / 94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland University Hospital
(b) Street address Lombard & Greene Sts
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3059 Stafford St
(If rural, give location)
(e) Citizen of foreign country? / (Yes or No)
If yes, name country

3 (a) **FULL NAME** John W. Eisenbraugh

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 213-28-6307

4. Sex: M. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Emma V.

6 (c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.) July 29, 1881

8. AGE: Years 65 | Months 9 | Days 7 | If less than one day: hr. min.

9. Birthplace Howard Co, Md
(Town, county, and state)

10. Usual Occupation Painter

11. Industry or business C. J. Bestrom

FATHER 12. Name Andrew Eisenbraugh

13. Birthplace Pa

MOTHER 14. Maiden Name Martha Toole

15. Birthplace Howard Co, Md

16 (a) Informant Mrs Emma V. Eisenbraugh

(b) Address 3059 Stafford St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-9-47 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet

Location Baltimore Md

18 (a) Funeral director Fred J. Cole

(b) Address 1708 W. Lombard St

(c) MAY 7 - 1947 (Date rec'd by registrar) Thos. Hilton Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-6 1947, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-30 1947 to 5-6 1947, and that I last saw h[illegible] alive on 5-6 1947.

Immediate cause of death Cardiac failure — Duration

Due to Coronary sclerosis

Due to

Other Conditions Pulmonary tuberculosis (include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D. Nuhs M.D.

Address Univ. Hosp. Date signed 5-6-47

VS 150

X

G51151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

G51151 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1612 madison ave
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1612 Madison ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** James Edwin Brown
3 (b) If veteran, name war —
3 (c) Social Security Account No. 213-01-9643

4. Sex M | 5. Color or race colored | 6 (a) Single, married, widowed, or divorced married
6 (b) Name of husband or wife Beatrice Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2, 1896

8. AGE: Years 50 | Months 10 | Days 3 | If less than one day hr. min.

9. Birthplace md (Town, county, and state)
10. Usual Occupation Porter
11. Industry or business

FATHER 12. Name Titus Brown
13. Birthplace md

MOTHER 14. Maiden Name Susie Woodland
15. Birthplace md

16 (a) Informant Beatrice Brown
(b) Address 1612 madison ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-8-47 (month) (day) (year)
(c) Cemetery or crematory St Peters
Location md

18 (a) Funeral director George B. Kelson
(b) Address 1303 Pressstonan St

19 1947 (Date) rec'd by reg. Washington Williams, M Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1947 at 9P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 10 1946 to 5/5 1947
and that I last saw him alive on 5/5 1947

	Duration
Immediate cause of death Adenoma Lung c	6 mo
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature B. J. Otatelin
Address 1612 Pa Ave Date signed 5/7/47 (M. D.)

X

G51152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G51152

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 609 Radnor Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 7/10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 609 Radnor Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Connolly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 3 - 1873

8. AGE: Years 73 | Months 9 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business Housework

FATHER
12. Name John Cochran
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary E. King
15. Birthplace Baltimore Md

16 (a) Informant Howard Mulligan
(b) Address 609 Radnor Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/8/47 (month) (day) (year)
(c) Cemetery or crematory St Marys Govans
Location Homeland Ave

18 (a) Funeral director John C. Moran
(b) Address 3600 E Baltimore St

19 (a) 1947 (Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to May 5 1947.
and that I last saw her alive on May 4 1947.

Immediate cause of death Cerebral hemorrhage — Duration 2 Days
Due to Arteriosclerotic Cardiovascular disease — Duration years (5/7/47)
Due to — Duration
Other Conditions — Duration
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Anthony J. Thomas M. D.
Address 4600 York Rd Date signed 5/5/47

V S 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G51453

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (931)

G51453 Registered No. B51453

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Arnolds Md.
(c) Hospital or institution: 6006 Bellona Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 year
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6006 Bellona Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John S. Bridges Jr.
3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W.	married

6 (b) Name of husband or wife Mary Stone
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 19 1880

8. AGE: Years	Months	Days	If less than one day
66	4	17	hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John S. Bridges
13. Birthplace Balto.

MOTHER
14. Maiden Name Mary E. Wells
15. Birthplace Pa.

16 (a) Informant Mary Stone Bridges
(b) Address Arnolds. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 9/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director John O. Mitchell Funeral
(b) Address 1918 Eutaw Place

19 (a) 1947 (Date filed by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 1947, at 7.30 M
21. I certify that death occurred on the date above stated; that I attended deceased from 1-1-1940, to 5-6-1947, and that I last saw h[illegible] alive on 5-6-1947

Immediate cause of death: Acute Congestive heart failure — Duration 3 hr.
Due to: Myocardial degeneration
Due to: Arteriosclerosis
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Howard F. Garner M. D.
Address 2604 Fairmount Blvd Date signed 5-7-47

VS 150

G51154

BC# B77464

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

G51154 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address —
(c) Hospital or institution: Woman's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED: Carroll
(a) State Md. (b) County Baltimore
(c) City or town Westminster Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 155 W. Maine St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME RAYMOND BRUCE HENDERSON

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 5/2/47

8. AGE: Years	Months	Days	If less than one day
—	—	1	— hr. — min.

9. Birthplace BALTIMORE, MARYLAND
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name RAYMOND MALVEE HENDERSON
13. Birthplace DAYTON, MO.

MOTHER
14. Maiden Name MARGARET CLAIRE SCHNITZLER
15. Birthplace NEW YORK, N.Y.

16 (a) Informant MOTHER
(b) Address 155 W. MAIN ST. WESTMINSTER, Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo MAY 6 1947

18 (a) Funeral director Commissioner of Health
(b) Address

MAY 7 — 1947 (Date rec'd by Local Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/3/47 19 , at 11 05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/2/47 19 to 5/3/47 19 , and that I last saw him alive on 5/3/47 19

Immediate cause of death	Duration
INTRACRANIAL HEMORRHAGE	
Due to PREMATURITY	
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation —
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. L. Swanson M. D.
Address Woman's Hospital Date signed 5/4/47

PLEASE WRITE IN UNFADING INK. Every item of information should be carefully supplied. The items marked * are important. Physicians: please write the causes of death clearly and legibly.

VS 1

G51155

BALTIMORE CITY HEALTH DEPARTMENT

BC# D77528 CERTIFICATE OF DEATH 1576

G51155 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Madison and Linden Ave

(c) Hospital or institution: Balto. Gen. Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days

(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 18 2 N Whitmore Ave

(If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) **FULL NAME** Charles Wesley Gillen (Newborn)

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Newborn

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 28 April 1947

8. AGE: Years	Months	Days	If less than one day
		5	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER

12. Name Charles David Gillis Jr.

13. Birthplace Balto Md

MOTHER

14. Maiden Name Dorsey

15. Birthplace Balto Md

16 (a) Informant mother

(b) Address 18 2 N Whitmore

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Local Johns Hopkins Medical Schoo MAY 6 1947

18 (a) Funeral director Commissioner of Health

(b) Address

MAY 7 - 1947 (Date rec'd by Registrar) (Signature of Registrar) Hinkley for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/3/47 19 at 2 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 28 Apr 1947 to 5/3/47 19

and that I last saw h[illegible] alive on 5/3/47 19

Immediate cause of death	Duration
Sudden Death	
Due to Patent Ductus Arteriosus	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy Patent Ductus Arteriosus

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Thomas C. Webster M.D.

Address Bal Gen Hosp Date signed 5/6/47

VS 150

X

Dr. 451156

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

C51156
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2314 Popular Grove St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2314 Popular Grove St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Shaw.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years	Months	Days	If less than one day
83	-	-	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name James Shaw
13. Birthplace County Monohan - Ireland

MOTHER
14. Maiden Name Anne
15. Birthplace County Tipary - Ireland

16 (a) Informant Miss A
(b) Address 2314 Popular Grove St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-8-47 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location - City -

18 (a) Funeral director Wiedefeld & Son
(b) Address Greenmount Ave & 22nd St.

19 (a) 1947 (b) [illegible] by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5th 1947, at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 4 1947 to Apr 5 1947 and that I last saw h. alive on Apr 5 1947.

Immediate cause of death — Duration
Myocardial insufficiency — 2 wks.
Due to Cardio Vascular Lesion — Yrs.
Due to Hyper tension - Arterio sclerosis — Yrs.
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 2200 Jarrett Bld Date signed Apr 6 1947

VS 150

G51457

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G51457

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 112 W. Randolph St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 112 W. Randall St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME Andrew Bayline (Bahnlein - Bahnlein - Bahline)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife (nee Rieländer) Maggie Elizabeth Bayline

6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Nov. 6, 1860

8. AGE: Years	Months	Days	If less than one day
86	6	2	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation at Home

11. Industry or business

FATHER
12. Name ? ?
13. Birthplace Germany

MOTHER
14. Maiden Name ? ?
15. Birthplace Germany

16 (a) Informant Mrs. Maggie Elizabeth Bayline
(b) Address 112 - W. Randolph St. Balto. 30 Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/9/47 (month) (day) (year)
(c) Cemetery or crematory London Park Cem.
Location Balto., Md.

18 (a) Funeral director A. Howard Evans
(b) Address 1400 E. Chas. St. Balto. Md.

19 (a) (Date rec'd by registrar) (b) Clinton Williams M.D. Registrar

MAY 7 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 1947, at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 2 1947 to May 6 1947 and that I last saw h[illegible] alive on May 5 1947

Immediate cause of death Cardiac Thrombosis — Duration 26 hrs

Due to Senile Myocarditis — Duration 6 mos

Due to Arteriosclerosis — Duration 2 yrs

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature E. T. Hewitt M.D.
Address 112 W. Randolph St. Date signed —

X

G51158

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G5I158 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 CAROLINE ST
(c) Hospital or institution: ST JOSEPHS Hospital
(d) Length of stay in hospital or inst: (yrs., mos., or days) 1-2 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 65

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 808 W LOMBARD (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME PETER A GRAHAM

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-07-6521

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S.

6 (b) Name of husband or wife ✓
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-09-81

8. AGE: Years	Months	Days	If less than one day
65	10	7	hr. min.

9. Birthplace BALTIMORE MD (Town, county, and state)
10. Usual Occupation Machinist Engineer
11. Industry or business National Enamel & Stamping Co.

FATHER
12. Name Peter
13. Birthplace Ireland.

MOTHER
14. Maiden Name Rosanna Mulholland
15. Birthplace Ireland.

16 (a) Informant Mrs. Bernadette
(b) Address 808 W. Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-9-47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Ave.

18 (a) Funeral director Charles W Taylewelling
(b) Address 703 McHenry St.

19 (a) (Date) MAY 7 1947 (b) registration Washington Millington MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-6 1947, at 4:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-9 1947 to 5-6 1947, and that I last saw h[illegible] alive on 5-6 1947.

Immediate cause of death	Duration
GENERALIZED CARCINOMA	
Due to CARCINOMA STOMACH	
Due to METASTHSIS LIVER	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John B Wells MD
Address St Jos Hosp Date signed 5-6-47

Dr Dodd
12 G51159 Ellington Bb

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G51159

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1526 N. Spring Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1526 N. Spring Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa Schroeder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 12, 1869

8. AGE: Years	Months	Days	If less than one day
77	4 7	7 24	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Benjamin Schroeder
13. Birthplace Germany

MOTHER
14. Maiden Name Mary
15. Birthplace Germany

16 (a) Informant John S chroeder
(b) Address 1524 N. Spring Street

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 5/8/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 S t. Paul S treet

MAY - 1947
(Date rec'd by registrar) Huntington Williams, M. D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5, 1947, at 9:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/3 1947 to 5/5/ 1947 and that I last saw her alive on 5/4/ 1947

Immediate cause of death Hypertensive cardio vascular renal disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

Duration
2

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Deibel M. D.
Address 1226 Hanover St. Date signed 5/6/47

G51160 BALTIMORE CITY HEALTH DEPARTMENT G51160
Registered No.

CERTIFICATE OF DEATH X 161c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 22 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County St. Marys
(c) City or town Leonardtown
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard Ignasius Mattingly, JR.

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 5, 1947

8. AGE: Years	Months	Days	If less than one day
—	—	2	hr. min.

9. Birthplace Leonardtown, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Bernard D. Mattingly
13. Birthplace Maryland.

MOTHER 14. Maiden Name Dorothy K. Lambert
15. Birthplace Washington, D.C.

16 (a) Informant Hosp. record
(b) Address 33rd & Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 8, 1947 (month) (day) (year)
(c) Cemetery or crematory St. Aloysius
Location Leonardtown Md.

18 (a) Funeral director W. L. Mattingly Sons
(b) Address Leonardtown, Md.

MAY 7 - 1947 (Date received by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1947, at 11:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 6 1947, to May 7 1947, and that I last saw h[illegible] alive on May 7 1947

Immediate cause of death: Erythroblastosis fetalis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: 0

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ludemia M. Young M. D.
Address Union Mem. Hosp. Date signed 5/7/47

Huntington Williams, M.D.

G51161

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G51161 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 48 Market Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Guy Sherwood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 24th 1901

8. AGE: Years 40 58 | Months 8 | Days 8 | If less than one day: hr. min.

9. Birthplace Greensboro N. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Charles S. Sherwood
13. Birthplace N. C.

MOTHER
14. Maiden Name Ida Reece
15. Birthplace N. C.

16 (a) Informant Robert S. Sherwood
(b) Address Greensboro N. C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 7th 1947 (month) (day) (year)
(c) Cemetery or crematory
Location Greensboro N. C.

18 (a) Funeral director Leo G. Cooke
(b) Address 1701-03 N. Patterson Park Ave

19 (a) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/1 1947 at 3:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull & intracranial Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-1-47 at 2:45 P.M. 8/3
(b) Where did injury occur? 1312 N. Rose St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? no
(d) Means of injury Fell to street

23. Signature Earl L. Virgin M.D. Medical Examiner.
Date signed 5-2-47

VS 181

X

G51162 DUPLICATE Off'l No. 75590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G51162

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2905 N. Charles
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Boy Matthai Baby Boy Matthai

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	—

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4, 1947

8. AGE: Years	Months	Days	If less than one day
			18 hr. 50 min.

9. Birthplace Baltimore, 18, MD.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Paul Frederick Matthai
13. Birthplace Baltimore, MD.

MOTHER
14. Maiden Name Patricia Cullen
15. Birthplace Penna.

16 (a) Informant Hospital Record
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Hospital Disposal

18 (a) Funeral director
(b) Address

19 (a) Date received by Local Registrar MAY 8 - 1947 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. **DATE OF DEATH** 4 April 1947, at 11-35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4 April 1947 to 4 April 1947 and that I last saw him alive on 4 April 1947

Immediate cause of death	Duration
Atelectasis Neonatorum	
Due to	
Due to	
Other Conditions Possible Intra Cranial Hemorrhage	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Malcolm G. Hunt M. D.

Address Union Mem. Hosp. Date signed 5-1-47

X

G51163

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. G51163

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Havana (If outside city or town limits, write RURAL and give town)
(d) Street No. 506 Lombillo (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country Cuba

3 (a) FULL NAME Ida Sabin Cohen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-4-43

8. AGE: Years 3 | Months 8 | Days 2 | If less than one day ..... hr. ..... min.

9. Birthplace Cuba (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Salina Arthur
13. Birthplace Cuba

MOTHER
14. Maiden Name Rose Cohen
15. Birthplace Cuba

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof May 9 1947 (month) (day) (year)
(c) Cemetery or crematory Colon
Location Havana, Cuba

18 (a) Funeral director Wm. Cook Dyer
(b) Address 1217 St. Paul St.

19 (Date received by registrar) MAY 9 - 1947 Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 1947, at 12:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 4 1947, to May 6 1947, and that I last saw h[illegible] alive on May 6 1947

Immediate cause of death: Congenital Heart disease — Duration: Life

Due to

Due to Tetralogy of Fallot

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 5/3/47

Major findings of operation: Pulmonic Stenosis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry L. Bahnson, M.D.
Address J.H.H. Date signed 5/7/47

X

G51164

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G51164 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calhoun & Fayette
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Cockeysville, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Noah L Offutt

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22, 1873

8. AGE: Years	Months	Days	If less than one day
73	9	15	— hr. — min.

9. Birthplace Granite, Md. (Town, county, and state)
10. Usual Occupation Lawyer
11. Industry or business

FATHER
12. Name T Jedric Offutt
13. Birthplace Md.

MOTHER
14. Maiden Name Maria Offutt
15. Birthplace Md.

16 (a) Informant Miss Mildred Offutt
(b) Address Cockeysville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/9/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Druid Ridge
Location Pikesville, Md
18 (a) Funeral director H. W. Means and Son
(b) Address 705 N. Calvert St
Acting for William J. Hyde

19 MAY 8 - 1947 (b) Registrar
(Filed by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1947, at 7:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1947 to May 7 1947 and that I last saw him alive on May 7 1947

Immediate cause of death	Duration
(a) Uremia, Cardiac dec'm pneum'a.	7 days
Due to Generalized arteriosclerosis with	unknown
Due to Arteriosclerotic heart disease	unknown
Arteriosclerotic kidney disease	
Other Conditions Pneumonia,	7 days

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

Signature Stanley B. Klyanovsky M. D.
Address Towson, Md. Hosp. Date signed 5-7-47

G51165

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

Registered No. G51165

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Calvert & 33rd St.
(b) Street address [redacted]
(c) Hospital or institution:
Union Memorial Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3400 Tardneas Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME [redacted]. Alban (Rose Elizabeth)

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Frank H. Alban

6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Sept. 10th 1900

8. AGE: Years 46 | Months 7 | Days 27 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Maryland. (Town, county, and state)

10. Usual Occupation Housewife; Tel. Operator

11. Industry or business

FATHER
12. Name Martin League
13. Birthplace Maryland.

MOTHER
14. Maiden Name Laura League
15. Birthplace Maryland.

16 (a) Informant Mrs. Laura Young
(b) Address 892 W. Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/10/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location 3801 Frederick Ave.

18 (a) Funeral director John J. Cowan & Son
(b) Address 901-903 Hollins St.

19 (a) MAY 8 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1947, at 1 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 17 1947 to May 7 1947, and that I last saw her alive on May 6 1947.

Immediate cause of death Coronary occlusion, acute — Duration

Due to Coronary sclerosis

Due to

Other Conditions Hypertensive Cardiovascular disease (Include pregnancy within 3 months of death)

Date of operation May 6th

Major findings of operation:

of autopsy: Coronary occlusion, acute

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wall Watkins, M.D. M. D.
Address Union Memorial Hosp. Date signed 7 May 47

X

G51166

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G51166

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3030 Windsor Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3030 Windsor Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ETHEL RUSSELL JONES

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife George T. Jones
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 3, 1879

8. AGE: Years	Months	Days	If less than one day
67	7	3	hr. min.

9. Birthplace Oswego Co., N. Y.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Richard Russell
13. Birthplace Oswego Co., N.Y.

MOTHER
14. Maiden Name Barbara E. Judd
15. Birthplace Oswego Co., N. Y.

16 (a) Informant Mr. George R. Jones son
(b) Address Holder Ave., Woodlawn

17 (a) Burial (b) Date thereof 5/9/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (Date rec'd by registrar) MAY 8 - 1947 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6, 1947, at 2: P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May No 1935, to May 6 1947, and that I last saw h[illegible] alive on May 6 1947.

Immediate cause of death	Duration
Cerebral apoplexy	
Arteriosclerosis	
Due to	
Uremia.	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Beadle M.D.
Address 1114 N. Mt. St. Date signed 5/7/47

VS 150

G51167

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 195c

G51167

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 306 S. Monroe St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 + 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 306 S. Monroe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH E. DeHOFF

3 (b) If veteran, name war	3 (c) Social Security Account No.
noen	noen

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16, 1867

8. AGE: Years	Months	Days	If less than one day
79	9	19	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name George P. DeHoff
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Deaver (Deaver)
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Laura DeHoff
(b) Address 306 S. Monroe St.

17 (a) Burial (b) Date thereof 5/8.47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Ave. Balto. 17, Md.

19 (a) MAY 8 - 1947
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5, 1947, at 5:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1946 to May 5 1947, and that I last saw her alive on May 1 1947.

Immediate cause of death	Duration
Cardiac Failure	
Due to Cardiac Hypertrophy & Dilatation	
Due to Arteriosclerosis & Hypertension	
Other Conditions Pneumonia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature K. Krulevitz, M. D.
Address 2116 W. Pratt St Date signed 5/7/47

Huntington Hospital

X

G51168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33B

Registered No. G51168

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 818 N. Mount St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Eli Booth. (Eli Boothe) ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Catherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1897

8. AGE: Years	Months	Days	If less than one day
49	4	13	hr. min.

9. Birthplace Marley, A. A. Co. Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Davidson Chemical Co

FATHER 12. Name Thomas Boothe

13. Birthplace Maryland

MOTHER 14. Maiden Name Mary ?

15. Birthplace Maryland

16 (a) Informant Mary B. Grasey

(b) Address 3026 Seamen Ave, Ebony Hill

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/11/47 (month) (day) (year)

(c) Cemetery or crematory Halle Meth Epis

Location Marley, A. A. Co. Maryland

18 (a) Funeral director William A. Jackson

(b) Address 916 Eutaw, Ave Balto

19 (a) MAY 8 - 1947 (Date received by registrar) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-7-1947 at 1 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 12 1947 to May 7 1947, and that I last saw him alive on May 7 1947.

Immediate cause of death Cardiac Failure — Duration

Due to Cardiac Decompensation

Due to Hemiplegia Cerebral Embolism

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles Hawkins M.D.

Address University Hosp. Date signed 5-7-47

VS 150

G51169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G51169

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sheen Spring Ave & Belvedere Ave
(c) Hospital or institution: Levindale 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 55

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits write RURAL and give town)
(d) Street No. Sheen Spring & Belvedere Aves (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ISAAC YOSELSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife 1585

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1853

8. AGE: Years	Months	Days	If less than one day
92			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Isaac -

13. Birthplace Russia

MOTHER 14. Maiden Name -

15. Birthplace Russia

16 (a) Informant Morris Yoselson

(b) Address 2624 Federal St Camden, Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-8-47 (month) (day) (year)

(c) Cemetery or crematory Mosher Kirkash Cem

Location Sheen Spring Ave

18 (a) Funeral director Isaac Lewis Inc

(b) Address 1738 E Balto St

19 (a) MAY 8 - 1947 Huntington Williams, M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-8 1947, at 6 a M

21. I certify that death occurred on the date above stated; that I attended deceased from October 1941 to 5-8 1947 and that I last saw h.m alive on 5-8 1947

Immediate cause of death Coronary thrombosis — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Henry Nagel M. D.

Address Levindale Home Date signed 5-8-47

VS 150

G51470

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

Registered No. G51470

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3814 Cottage Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3814 Cottage Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Zetta Streett

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Leo Bernard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: Years 86 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Kopel
13. Birthplace Russia

MOTHER 14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Irvin Streett
(b) Address 1519 N Payson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-8-47 (month) (day) (year)

(c) Cemetery or crematory Rosedale
Location

18 (a) Funeral director Jos Rauch Inc
(b) Address 1439 E Balto St

19 Date received by registrar MAY 8 1947 Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1947 at 9:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1946 to May 7 1947 and that I last saw alive on May 7 1947

Immediate cause of death: Hypertensive Cardiovascular disease
Chronic Nephritis

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert T. Levy
Address 1844 W. North Ave Date signed 5/8/47

VS 150

G51171

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G51171

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3203 Southern Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3203 Southern Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY HARRER

3 (b) If veteran, name war #1

3 (c) Social Security Account No. 213-28-0392

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 13, 1891

8. AGE: Years 55 | Months 6 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Fireman, Ret.

11. Industry or business Balto. City Fire Dep't.

FATHER
12. Name Louis Harrer
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mary Reges
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. George Baxter
(b) Address 3203 Southern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/ 8/ 47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS INC.
(b) Address NORTH AVE. & BROADWAY

19 MAY 8 - 1947 (Must be filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1947, at 11.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 4, 1947, to May 5, 1947, and that I last saw him alive on May 5, 1947

Immediate cause of death	Duration
Coronary Thrombosis	10 mins.
Due to Arteriosclerosis	Unknown
Due to Coronary Sclerosis	Unknown
Other Conditions Arthritis (hypertrophic) (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Philip Artigiani M. D.
Address 2942 E. Fayette St. Date signed 5/6/47

VS 150

651172

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 83a

Registered No. 651172

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1610 Harlem Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-3
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1610 Harlem Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Moss

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-16-3196

4. Sex: M | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Jane

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years: 53 | Months: 12 | Days | If less than one day: hr. min.

9. Birthplace Dinwiddie Co. Va (Town, county and state)

10. Usual Occupation Sexton

11. Industry or business

FATHER
12. Name Henry Moss
13. Birthplace Dinwiddie Co Va

MOTHER
14. Maiden Name Hattie Kate
15. Birthplace Dinwiddie Co Va

16 (a) Informant Hazle Moss
(b) Address 1610 Harlem Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 8 (month) (day) 1947 (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location Dinwiddie Co Va

18 (a) Funeral director Hunter Williams
(b) Address 15 McElderry St

19 MAY 8 - 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1947, at 7:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1 1947 to 5/4 1947 and that I last saw h[illegible] alive on 4/4/47

Immediate cause of death Cerebral Hemorrhage 4 days — Duration

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
(f) Signature Jewel Cone M.D.
Address 1131 Harlem Ave Date signed 5/8/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51173

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

Registered No. G51173

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 114 N Carey Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George T. Shipley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Margaret Shipley

6 (c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.) Dec. 5, 1887

8. AGE: Years: 59 | Months: 5 | Days: 1 | If less than one day: hr. min.

9. Birthplace: Baltimore Md. (Town, county and state)

10. Usual Occupation: Superintendent Can Co.

11. Industry or business: Canning

FATHER
12. Name: George Shipley
13. Birthplace: Baltimore Md.

MOTHER
14. Maiden Name: Bertha Tiepel
15. Birthplace: Baltimore Md.

16 (a) Informant: Patient
(b) Address: Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: May 10th (month) (day) (year)
(c) Cemetery or crematory: London Park
Location: Balto

18 (a) Funeral director: Wm. H. Funeral Home
(b) Address: 1911 Orleans St.

19 (a) MAY 8 20 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/6/47, 19, at 10:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/1/47 19 to 5/6/47 19, and that I last saw h alive on 5/6/47.

Immediate cause of death: acute staphylococcic pyelonephritis

Due to: Salpingitis & Cholecystitis

Due to:

Other Conditions: Acute Chem. Pneumonitis

(Include pregnancy within 3 months of death)

Date of operation: 5/1/47

Major findings of operation: Cholecystitis acute suppurative

of autopsy: Pathological

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence, at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury JOSEPH D'ANTONIO

23. Signature Joseph D'Antonio M.D.

Address 1 West Lexington St. Date signed 5/7/47

X

G51174

Grahe

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G51174

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 633 N Bentalou St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-5
(e) Length of stay in Baltimore (yrs., mos., or days) 70yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 633 N Bentalou (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John A Grahe

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Hallie F Grahe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sep 12th 1876

8. AGE: Years	Months	Days	If less than one day
70	7	25	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Fireman
11. Industry or business Church House

FATHER
12. Name John Grahe
13. Birthplace Md

MOTHER
14. Maiden Name Dont Know
15. Birthplace Md

16 (a) Informant Mrs Clarence Carey
(b) Address 633 N Bentalou St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 10- (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location Frederick Md

18 (a) Funeral director Ullsich Funeral Home
(b) Address 2042 E Orleans St

MAY 8 1947

19 (a) (Date rec'd by registrar) (b) Huntington Williams MD

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7th 1947 at 10 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 30 1947 to May 7 1947, and that I last saw him alive on May 7 1947.

Immediate cause of death Coronary Thrombosis — Duration 5 Min

Due to Coronary Sclerosis — years

Due to

Other Conditions Hypertension — years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C J Mendelis
Address 651 N Bentalou Date signed 5/8/47 M D

V S 130

X

651175

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

Registered No. 651175

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1216 E.Federal Street
(c) Hospital or institution: 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 60 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
City or town Baltimore 9
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1216 E.Federal Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Wilkening

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Elizabeth R. Gassner
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) May 16, 1871

8. AGE: Years	Months	Days	If less than one day
75	II	20	######## hr. ######## min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired, Leaverman
11. Industry or business P.R.R.

FATHER
12. Name August Wilkening
13. Birthplace Germany

MOTHER
14. Maiden Name Helen A. Gottlieb
15. Birthplace Germany

16 (a) Informant Mr. Henry F. Wilkening
(b) Address 1216 E.Federal Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/10/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E.North Avenue, Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

MAY 8 - 1947 (Date rec'd by registrar)

(b) Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/6/47 19 ..., at 2P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 22 1939 to May 6 1947 and that I last saw h. im alive on May 6 1947

Immediate cause of death: Carcinoma Prostate — Duration: 1 yr 7 mo.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. M. Wilson, M.D.
Address 617 W. 40th St. Date signed 5/7/47

X

G51176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G51176

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert
(c) Hospital or institution: Mt Union Memorial Hospital 9-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 61 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt.
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 503 East 35th St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME. Marion Wesley Bennett Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-15-7873

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Anna M Bennett

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) March 3, 1886

8. AGE: Years 61 | Months 2 | Days 4 | If less than one day ____hr. ____min.

9. Birthplace Balt Md (Town, county, and state)

10. Usual Occupation Yellow Cab Co.

11. Industry or business Chauffeur

FATHER
12. Name Robert M Bennett
13. Birthplace Balt. Md

MOTHER
14. Maiden Name Kate Lynch
15. Birthplace Balt. Md

16 (a) Informant Anna M Bennett
(b) Address 503 E 35th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 9. 1947 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave

18 (a) Funeral director Mrs. Mrs. John H. Deibel & Son
(b) Address 5311 Edmondson Ave

19 MAY 8 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1947 at 1:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 27 April 1947, to May 7 1947, and that I last saw h. alive on May 7 1947.

Immediate cause of death: Respiratory failure — Duration

Due to: Carcinoma of the Stomach.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Carcinoma of Stomach

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ruth Lane M. D.
Address Union Memorial Hospital Date signed 5-7-47

CLASSEN X

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54a

G51177 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp. 27-10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13da
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 12
(If outside city or town limits, write RURAL and give town)
(d) Street No. 711 Radnor Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Alice M. Walsh

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: fem.

5. Color or race: Wh.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Thomas Walsh

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 22, 1908

8. AGE: Years 38 Months 4 Days 16 If less than one day hr. 5 min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

MOTHER / FATHER

12. Name John H. Heuerman

13. Birthplace Balto

14. Maiden Name Annie E. Cross

15. Birthplace Balto.

16 (a) Informant Hospital Record

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/9/47 (month) (day) (year)

(c) Cemetery or crematory Mass. Cath. Location Old Frederick Rd

18 (a) Funeral director John A. Mc Vey

(b) Address 4851 Greenmount Ave

19 MAY 8 - 1947 (b) Huntington for Williams, Mill
(Registered by local reg.)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-6- 1947, at 12 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-23 1947 to 5-6 1947 and that I last saw h[illegible] alive on 5-6 1947.

Immediate cause of death	Duration
resp. failure	
Due to 4 da. post op PO	
brain tumor	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 5-2-47

Major findings of operation: frontal lobe glioma

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Gerlach M. D.

Address Mercy Hosp. Date signed 5-6-47

VS 150

G51178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G51178

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3901 Old York Road
(c) Hospital or institution: Home - 9-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., ~~mos.~~, or ~~days~~) 54

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3901 Old York Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** William Henry Jackson Sr

3 (b) If veteran, name war None

3 (c) Social Security Account No. 220-09-9559

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Barbara Elizabeth
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) 8 July 1889

8. AGE: Years	Months	Days	If less than one day
57 58	9	29	____ hr. ____ min.

9. Birthplace Philadelphia, Penn.
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Insurance

FATHER
12. Name William H. Jackson
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name ~~Emma~~ Roth Nagel
15. Birthplace Germany

16 (a) Informant Wife
(b) Address 3901 Old York Rd. Balto. Md.

17 (a) Burial (b) Date thereof May 10/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Frederick Road

18 (a) Funeral director John C Moran
(b) Address 3660 E Baltimore St

19 (a) MAY 8 - 1947 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 May 1947, at 6:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4 Jan. 1947 to 7 May 1947 and that I last saw h[illegible] alive on 7 May 1947.

Immediate cause of death	Duration
Cerebral hemorrhage (right hemiplegia)	
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles H. Williams M. D.
Address 1331 Reisterstown Rd. Pikesville 8, Md. Date signed May 8 1947

VS 150

G51179

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1648

G51179
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Morgue 27-10 doa
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 723 Springfield ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert J. Hand

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	M

6 (b) Name of husband or wife Rosalie M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26-1904

8. AGE: Years	Months	Days	If less than one day
42	9	10	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John Hand
13. Birthplace ?

MOTHER
14. Maiden Name Mary Scales
15. Birthplace ?

16 (a) Informant Rosalie M.
(b) Address 723 Springfield ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 9-47 (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director John G. McGann
(b) Address 4201 Fremont ave.

19 (a) MAY 8 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-6- 1947, at 2 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH — Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 9/1

(a) Date of injury 5/6/47 at ? M.
(b) Where did injury occur? Clifton Park Lake
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury found drowned.

23. Signature Earl L. Cogen M.D.
Medical Examiner.
Date signed 5-7-47

G51180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓108

Registered No. G51180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave
(c) Hospital or institution: Edgewood Nurseries Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 wks
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2606 Hudson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Poznaniak (Posaniak) ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	widowed

6 (b) Name of husband or wife Magdalene Poznaniak

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 15 1865

8. AGE: Years	Months	Days	If less than one day
81 82	4	23	hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Josyah Poznaniak
13. Birthplace Poland

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Joseph Pietrowicz
(b) Address 2606 Hudson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/10/47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cemetery
Location German Hill Rd.

18 (a) Funeral director John J. Duda
(b) Address 2626 Hudson St.

MAY 8 - 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1947, at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 8 1947, to May 7, 1947, that I last saw him alive on May 7, 1947.

Immediate cause of death	Duration
(a) Terminal Uremia (Renal)	
Terminal - Coronary Thrombosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Tuszewski M. D.
Address 2529 East 4th Date signed

X

G51181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 186a

G51181 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton + Wilkens Aves.
(c) Hospital or institution:
St. Agnes' Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Catonsville
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 103 Kenwood Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Emma F. Taylor EMMA F. TAYLOR

3 (b) If veteran, name war ******* | 3 (c) Social Security Account No. *******

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOWED

6 (b) Name of husband or wife WALTER C. TAYLOR
6 (c) If alive, give age D. years

7. Birth date of deceased (mo., day, yr.) 2-11-1875

8. AGE: Years	Months	Days	If less than one day
72	2	26	hr. min.

9. Birthplace Pa.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business AT HOME

FATHER
12. Name JULIUS L. WOLF
13. Birthplace GERMANY

MOTHER
14. Maiden Name AMELIA SCHNEFE
15. Birthplace GERMANY

16 (a) Informant MR. CHARLES J. WISE
(b) Address 109 KENWOOD AVE. CATONSV.

17 (a) Burial (b) Date thereof May 10/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore, Maryland

18 (a) Funeral director F.B. WIPPERT & SON
(b) Address 1300 EUTAW PLACE....17

19 (a) 1947 (b)
(Date filed by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1947 at 3:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 17 1947 to May 7 1947 and that I last saw h.. alive on May 7 1947

Immediate cause of death	Duration
Cardiac failure	
Due to —	
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation 4/13/47 Major findings of operation: Closed reduction
2 fract. L forearm, + fract. Rt. Radius
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accidental
(b) Date of occurrence 4/12/47 at ? M
(c) Where did injury occur? 10[illegible] Kenwood Ave. Baltimore Md.
(City or town)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Means of injury Fell downstairs at home

23. Signature Howard L. Mercein, M.D.
Address St Agnes Hosp. Date signed 5-7-47

Howard L. Mercein, M.D.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G51182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G51182 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette Ave
(c) Hospital or institution Bon Secours
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Months
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2230 Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Anna Stapp Stapp

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Leo Stapp

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.) October 9 1884

8. AGE: Years 64 | Months 6 | Days 28 | If less than one day hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation Cook

11. Industry or business Bon Secours Hospital

FATHER
12. Name Henry Acosta
13. Birthplace Austria

MOTHER
14. Maiden Name —
15. Birthplace Austria

16 (a) Informant Leo Stapp
(b) Address 142 Mrs Ohail St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 9 47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md

18 (a) Funeral director J. B. Wishart Son
(b) Address 16 E Lexington St

19 (a) Filed May 9 1947 Wilmington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6th 1947 at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2 — 9 1947 to May 6 1947, and that I last saw h[illegible] alive on May 6 1947.

Immediate cause of death Respiratory Failure — Duration

Due to Metastatic Carcinoma - Pharynx

Due to Uterine - Diathesis of St. Louis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 11-26-45
Major findings of operation: Ulcer Ca of uterus Exploratory Laparotomy
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William F. Bamm M. D.
Address Bon Secours Hosp Date signed 5-6-47

G51183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 163 B

G51183 Registered No.

Every item of information should be carefully supplied. The write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Eve correct age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Stafford Hotel
(c) Hospital or institution: Balto, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maine (b) County
(c) City or town Topsham
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7 Pleasant St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H. (Parnell) Pennell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Elizabeth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14-1899

8. AGE: Years	Months	Days	If less than one day
47	7	23	hr. min.

9. Birthplace Maine
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name ✓
13. Birthplace ✓

MOTHER
14. Maiden Name ✓
15. Birthplace ✓

16 (a) Informant Mrs. Elizabeth Pennell
(b) Address 7 Pleasant Street

17 (a) Burial (b) Date thereof 5-12-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Brunswick-Maine

18 (a) Funeral director Leonard J. Luck
(b) Address 5305 Harford Rd.

19 (a) 1947 (b)
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7, 1947 at 5P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Seconal Poisoning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-7-47 at M.
(b) Where did injury occur? Stafford Hotel-Balto Md
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No data
(d) Means of injury Swallowing

23. Signature Earl L. Wagner M.D.
Medical Examiner
Date signed 5-8-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51184

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 E

G51184 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3310 Gibbons (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANGELO PERTICONE

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Josephine | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 17, 1865

8. AGE: Years 81 | Months 8 | Days 20 | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Bellevue Hotel

11. Industry or business

FATHER 12. Name ✓

13. Birthplace ✓

MOTHER 14. Maiden Name ✓

15. Birthplace ✓

16 (a) Informant Mrs. Josephine Perticone

(b) Address 3310 Gibbons ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 10 1947 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore, Maryland

18 (a) Funeral director Leonard J. Pumo

(b) Address 5305 Harford Rd.

19 (a) (Date received by registrar) (b) Huntington Williams M.D. Registrar

MAY 8 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/7 1947, at 3:46 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/16 1947, to 5/7 1947, and that I last saw h.[illegible] alive on 5/7 1947.

Immediate cause of death Cardio resp. failure — Duration

Due to Ca caecum metastasis

Due to Bilirubin, hyperchloremia pulmonary congestion

Other Conditions jaundice

(Include pregnancy within 3 months of death)

Date of operation 4/25

Major findings of operation: Ca caecum ileo ileal fistula

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J. B. Rosenberg M. D.

Address Univ. Hosp. Date signed 5/8/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51185

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH V94a

G51185 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1018 Herndon Court
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) Y
(e) Length of stay in Baltimore (yrs., mos., or days) 5

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1018 Herndon Court-25
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Patrick J. Ducey

3 (b) If veteran, name war

3 (c) Social Security Account No. 116-12-9552

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elizabeth Ducey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31-1886

8. AGE: Years	Months	Days	If less than one day
60 64	- 11	- 7	hr. min.

9. Birthplace Garland
(Town, county, and state)
10. Usual Occupation Ships fitter
11. Industry or business U. S Coast Guard

FATHER
12. Name James Patrick Ducey
13. Birthplace Ireland

MOTHER
14. Maiden Name Julia Bowman
15. Birthplace Ireland

16 (a) Informant Mrs Elizabeth Ducey
(b) Address 1018 Herndon Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 10-47. (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Gov. Ritchie Highway

18 (a) Funeral director Milton Schilling
(b) Address 3914 Hanover St. 25-

MAY 8 1947 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7th 1947, at 1 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 15 1946 to May 6 1947. and that I last saw him alive on May 6 1947.

Immediate cause of death Coronary Thrombosis

Due to Atherosclerosis of the Coronary Blood vessels

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
Several years
Last attack 1 day

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature J. Neubauer M. D.
Address 914 Patapsco Ave. Date signed 5-7-47

X

G51786 ✓ G51786

514317

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

134a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Leesburg (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edna E. Harding

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Wm. Harding

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) 11-11-90.

8. AGE: Years 56 | Months 5 | Days 27 | If less than one day ... hr. ... min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Isaac Dixon

13. Birthplace W. Va

MOTHER 14. Maiden Name Virginia Bowers

15. Birthplace W. Va.

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof MAY 9-47 (month) (day) (year)

(c) Cemetery or crematory Union Cemetery

Location Leesburg Va.

18 (a) Funeral director John E. Mitchell & Son

(b) Address 1766 Eutaw Pl.

19 (a) MAY 8 1947 (Date received by registrar) (b) Huntington Hall Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 1947 at 12 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 28 1947 to May 8 1947, and that I last saw her alive on May 8 1947.

	Duration
Immediate cause of death Cerebral hemorrhage Cerebral vascular accident	4 Days
Due to Hypertension & Cerebral vascular accident	
Due to	
Other Conditions Coronary Sclerosis & generalized arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation 5-2-47

Major findings of operation: Stephens calculus not removed because of poor condition of patient

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E. Green M. D.

Address John Hopkins Date signed 5-9-47

X

G5187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92E

Registered No. G5187

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1112 E. Lanvale Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1112 E. Lanvale Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Goodling

3 (b) If veteran, name war: No
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Married

6 (b) Name of husband or wife: Ethel Goodling
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16, 1892

8. AGE: Years	Months	Days	If less than one day
55	0	21	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business Canton Railroad

FATHER
12. Name William G. Goodling
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Mary M. Ferree
15. Birthplace Pennsylvania

16 (a) Informant Ethel May Goodling
(b) Address 1112 E. Lanvale St.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 5/10/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) MAY 9 1947 (Date received by registrar) (b) Huntington Williams M.D. (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7, 1947, at 5:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1947 to May 7 1947 and that I last saw h alive on May 1 1947

Immediate cause of death: Carcinoma Pelvis — Duration: 6 mos.
Due to: Endometrioma — 3 yrs.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. D. Thomas M. D.
Address 3136 Maryland Date signed May 9 1947

3136. Thomas, X

G51188 ✓ G51188

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1634

Registered No. ✓

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D. of A
(c) Hospital or institution: Women's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 802 Whitelock Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella W. Davis ✓

3 (b) If veteran, name war W
3 (c) Social Security Account No. none

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Samuel H. Davis
6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) July 16th 1902

8. AGE: Years 44 | Months 9 | Days 21 | If less than one day ____ hr. ____ min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Lawrence S. Jacobs
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Balto. Md.

16 (a) Informant Samuel H. Davis
(b) Address 802 Whitelock St.

17 (a) Cremation (b) Date thereof 5/9/47
(Burial, cremation, ~~or removal~~) (month) (day) (year)
(c) ~~Cemetery or~~ crematory Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

MAY 9 - 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/7 1947, at 4:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to Illuminating gas
Due to
Other Conditions Despondency
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5/7/47 at about 5 P.M.
(b) Where did injury occur? 802 Whitelock St
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury Gas inhaling from 2 unlit burners

23. Signature G. J. Galbraith M.D.
Medical Examiner.
Date signed 5/8/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51189

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G51189 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.S.P.
(b) Street address 1228 E. North Ave
(c) Hospital or institution:
84
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2313 E. Chase St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Connolly

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-12-7466

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	widowed

6 (b) Name of husband or wife Lena M. Connolly

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug - 1869

8. AGE: Years	Months	Days	If less than one day
77	9		hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business retired

FATHER
12. Name James Connolly
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Stokes
15. Birthplace Ireland

16 (a) Informant Mr. Friebel
(b) Address 1228 E. North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 10 47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Philip Herwig Jr.
(b) Address 2024 Orleans St.

MAY 9 - 1947 (Date rec'd by Registrar) (b) Interior for Williams M.E. (Registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/7 1947 at 3:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to h.s death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. F. Furbush M.D. (Medical Examiner.)
Date signed 5/8/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

✓ G51190 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2448 Callow Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2448 Callow Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George L Bank

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-6566

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Sylvia Nee Fox
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 2, 1903

8. AGE: Years	Months	Days	If less than one day
44	4	6	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation
11. Industry or business Salesman

FATHER
12. Name Simon Bank
13. Birthplace Russia

MOTHER
14. Maiden Name Martha Goldie Bank
15. Birthplace Russia

16 (a) Informant Mr Herman Gilden
(b) Address 2448 Callow Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 9, 1947 (month) (day) (year)
(c) Cemetery or crematory Hebrew Washington Road
Location Washington Blvd

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

MAY 9 - 1947 (Date rec'd by registrar) Huntington Williams M.D. (Signature of registrar)

MEDICAL CERTIFICATION 6.40

20. DATE OF DEATH May 8 1947, at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from [illegible] 1941, to May 8 1947, and that I last saw h[illegible] alive on May 8 1947

Immediate cause of death [illegible] Coronary occlusion — Duration 4 hrs

Due to

Due to

Other Conditions Hardening of the arteries — 1945

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature [illegible]
Address 1324 Eutaw Pl Date signed 5/7/47

V S 150

94a

G5191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

✓ G5191 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4307 Granada Av
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 15-10
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltotity
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4307 Granada Av (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Charles Barry Dempsey

3 (b) If veteran, name war none

3 (c) Social Security Account No. 214-12-9679

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Margaret Dempsey

6 (c) If give, give age 67 years

7. Birth date of deceased (mo., day, yr.) March 17 1869

8. AGE: Years 78 | Months 1 | Days 20 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Insurance

FATHER 12. Name John B Dempsey

13. Birthplace Balto Md

MOTHER 14. Maiden Name Louise Barry

15. Birthplace Balto Md

16 (a) Informant Mrs M E Dempsey - wife

(b) Address 4302 Granada Ave 15

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 10 47 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Balto Md

18 (a) Funeral director Stewart Morris Co

(b) Address 108 W North Ave

19 (a) MAY — 1947 (Date received by registrar) (b) Huntington for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1947; at 10-20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1946, to May 7 1947, and that I last saw him alive on April 30 1947

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Chronic Parenchymatous nephritis	2 yrs
Due to Chronic Paralytic	5 months
Other Conditions	

(Include pregnancy within 3 months of death.)

Date of operation Supra Pubic Cystotomy

Major findings of operation Hypertrophied Prostate

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E Gill Hall

Address 1631 E North Ave Date signed M. D. 5/8/47

VS 150

X

651193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Registered No. 651193

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 Eutaw Place
(c) Hospital or institution: Ellinger Stone

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) Abt. 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 603 N Calvert (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Humbert

3 (b) If veteran, name war — ? — | 3 (c) Social Security Account No. — ? —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept-21 1884

8. AGE: Years 62 | Months 7 | Days 15 | If less than one day hr. min.

9. Birthplace Alsace-Lorraine (Town, county, and state)

10. Usual Occupation Clerk with the

11. Industry or business Salvation Army

FATHER: 12. Name Louis Humbert

13. Birthplace France

MOTHER: 14. Maiden Name Louise Ronfort

15. Birthplace France

16 (a) Informant Maj. Chas. Britton (friend)
(b) Address 336 St Paul Cty 2

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 9 47 (month) (day) (year)

(c) Cemetery or crematory Woodlawn N
Location BALTIMORE, MARYLAND

18 (a) Funeral director Stewart & Company
(b) Address 108 W Mt Royal Ave.

MAY 9 - 1947 (Date rec'd by registrar) Huntington Williams M.D.

VS 150 Woodlawn

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/6/47 19, at 2 o'clock A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/10/46 19 to Death 19; and that I last saw h[illegible] alive on 5/1/47 19

Immediate cause of death Carcinoma Pancreas — Duration 8 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John C Downs, M.D.
Address 711 Med Arts Bldg Date signed 5/8/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G51193

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division ST
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1015 N. Arlington Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel W. Winder

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Negro	Widowed

6 (b) Name of husband or wife Carrie B.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-29-1874

8. AGE: Years	Months	Days	If less than one day
72	11	9	hr. min.

9. Birthplace Lancaster Co. Va (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name John H. Winder
13. Birthplace Whitestone, Va

MOTHER
14. Maiden Name Carrie Campbell
15. Birthplace Whitestone, Va

16 (a) Informant John Winder
(b) Address 1939 Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 11 47 (month) (day) (year)
(c) Cemetery or crematory Whitestone
Location Whitestone, Va

18 (a) Funeral director Rea. H. Kelson
(b) Address 303 Pratt St

MAY 9 - 1947 (Date received by registrar) (b) Evelyn Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-8 1947 at 3:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-2 1947 to 5-8 1947 and that I last saw him alive on 5-8 1947.

Immediate cause of death	Duration
Uremia	
Due to Cardio-renal syndrome	5 days
Due to	
Other Conditions Hypertensive Heart Disease (Include pregnancy within 3 months of death)	

Date of operation None

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. R L Jackson M.D. (Attended)
Address Provident Hospital Baltimore, Md Date signed 5-8-47

G51191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G51194 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 71
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 523 Campbell Alley
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES STINNEY

3 (b) If veteran, name war: World War I.
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 21, 1900

8. AGE: Years	Months	Days	If less than one day
46 47	5	11	hr. min.

9. Birthplace Harrisburg, Penna. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Charles T. Stinney
13. Birthplace Harrisburg Penna.

MOTHER
14. Maiden Name Ella ?
15. Birthplace Harrisburg, Penna.

16 (a) Informant Cora Winters
(b) Address 1129 Brewer Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/12/47 (month) (day) (year)
(c) Cemetery or crematory National Cemetery
Location Frederick Avenue

18 (a) Funeral director A. Galstead
(b) Address 918 Druid Hill Ave.

MAY 8 - 1947 (Date rec'd by Registrar) Wintington Williams M.D. Registrar

VS 191

MEDICAL CERTIFICATION P

20. DATE OF DEATH May 2 1947, at 10:50 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subdural Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-30-47 at 10:00 P M. ? 17/1
(b) Where did injury occur? 500 Blk. Camel Street
(c) Did injury occur at home, on farm, industrial place, in public place? Putlic Place While at work? No
(d) Means of injury Fell to street

23. Signature Earl L. Kaye M.D.
Medical Examiner.
Date signed 5-3-47

G5T195

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G5T195

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 504 St. Mary's St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 504 St. Mary's St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country No.

3 (a) FULL NAME Lavinia Payne

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife William H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 9, 1864

8. AGE: Years 82 | Months 4 | Days 27 | If less than one day hr. min.

9. Birthplace Hicksburg Dorchester Co. (town, county, and state)

10. Usual Occupation Unemployed.

11. Industry or business

FATHER
12. Name Nathaniel Cook
13. Birthplace Hicksburg Dorchester Co.

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Madelene Truetto
(b) Address 504 St. Mary's St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/9/47 (month) (day) (year)

(c) Cemetery or crematory National Cemetery
Location Frederick Avenue

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

MAY 9 - 1947 (Date rec'd by registrar) Registrar for Williamsport

VS 150

MEDICAL CERTIFICATION 30

20. DATE OF DEATH May 5, 1947 at 1 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/26/46 to 5/5/47 19..., and that I last saw h[illegible] on 5/4/47

Immediate cause of death: Cerebral Hemorrhage — Duration 1 day

Due to Generalized Arteria Sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 5/6/47

X

G51196

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G51196

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2315 E. Lafayette Ave
(c) Hospital or institution: d

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltor (If outside city or town limits, write RURAL and give town)
(d) Street No. 2315 E. Lafayette Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa K. Bereis

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife George
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7th 1870

8. AGE: Years 76 | Months 10 | Days - | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Housekeeper
11. Industry or business

FATHER
12. Name George
13. Birthplace Germany

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Mrs George Meisel
(b) Address 2315 E. Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-10th 1947 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Holy Redeemer
Location Belair Road

18 (a) Funeral director Leo G. Leavitt
(b) Address 1701-03 N. Patterson Park ave

19 (a) Date rec'd by Registrar MAY 9 1947 (b) Registrar Livingston Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-7th 1947, at 2.50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from January 7 1947 to May 7 1947 and that I last saw her alive on May 7 1947

Immediate cause of death	Duration
Cardiac Decompensation	4 Weeks
Secondary Uremia and Cachexia	
Due to Carcinoma of Stomach	2 Years
and Intestines	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert Greenberg M. D.
Address 2055 E. North Ave Date signed 5-8-47

X

G5E197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G5E197

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County —
(c) City or town BALTO. (If outside city or town limits, write RURAL and give town)
(d) Street No. 406 OLD ORCHARD RD. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD A HAIGLEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mrs. Matilda G. Haigley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11 - 1891

8. AGE: Years	Months	Days	If less than one day
55-6 years	0	26	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Supt. Arundel Ice Cream
11. Industry or business Co.

FATHER
12. Name Alphonz Haigley.
13. Birthplace Germany.

MOTHER
14. Maiden Name Margaret Reis
15. Birthplace Germany.

16 (a) Informant Mrs. Matilda G. Haigley
(b) Address 401 Old Orchard Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/10/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director Geo. E. Beyer Jr
(b) Address 1512 Hollins St

19 (a) MAY 9 - 1947 (Date rec'd by local registrar) (b) Funeral Director Williams MD

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 7 1947, at 2 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from MAY 3 1947 to MAY 7 1947 and that I last saw him alive on MAY 7 1947

Immediate cause of death	Duration
CARDIAC RUPTURE	
Due to CORONARY THROMBOSIS	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. N. Natale Jr. M.D.
Address Bon Secours Hospital Date signed 5/7/47

G5I198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G5I198 108

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Lexington
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 307 Aigburth Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country Aigburth

3 (a) FULL NAME Patricia Roper

3 (b) If veteran, name war No
3 (c) Social Security Account No. No

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: None

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Sept. 1 1940

8. AGE: Years 6 yrs | Months 8 | Days 6 7 | If less than one day: hr. ____ min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name George Roper
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Ann Chase
15. Birthplace Balto. Md.

16 (a) Informant Father
(b) Address

17 (a) Burial (b) Date thereof 5/12/47
(Burial, cremation, or removal) (Month) (day) (year)
(c) Cemetery or crematory Mt. Wilson
Location Towson, Md.

18 (a) Funeral director John Burns' Sons
(b) Address Towson, Md.

19 (a) Date rec'd by local reg. MAY 9 - 1947 (b) Registered by Ellington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 1947, at 6:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-7 1947, to 5-8 1947 and that I last saw her alive on 5-8 1947

	Duration
Immediate cause of death Pleuropneumonia	12 hrs
Due to Ruptured Ventricle	?
Due to	over
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William O. Gentry M.D.
Address Mercy Hosp. Date signed 5-8-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

65199

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 65199

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 317 N. Hoffman St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 317 N. Hoffman St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William Thomas Boulden

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-03-939

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Josephine B.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1899

8. AGE: Years 48 | Months 2 | Days 28 | If less than one day hr. min.

9. Birthplace Charlotte Court House, Va (Town, county, and state)

10. Usual Occupation Mechanic

11. Industry or business

FATHER
12. Name James Thomas Boulden
13. Birthplace Charlotte Court House, Va

MOTHER
14. Maiden Name Laura Wheeler
15. Birthplace Charlotte Court House, Va

16 (a) Informant Mrs. Josephine Bates Boulden
(b) Address 317 N. Hoffman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 9 1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Hyllard
(b) Address 1631 Druid Hill Ave.

19 (a) MAY 9 - 1947 (Date rec'd by Registrar) (b) Huntington-Williams Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5, 1947 at 1 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-29 1947 to 5-5 1947.
and that I last saw h— alive on 5-5 1947.

Immediate cause of death: Coronary Thrombosis — Duration: 1 day

Due to: Hypertensive Heart Disease — Duration: 3 yrs

Other Conditions: Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr. Boatman Higgins M. D.
Address 243 [illegible] Date signed 5/9/47

VS 150

G52500

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

✓ G52500 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 550 Mc Mechen St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Lida Phillips

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Married

6 (b) Name of husband or wife David Phillips
6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) May 15th 1888

8. AGE: Years	Months	Days	If less than one day
58	11	21	hr. min.

9. Birthplace Eastern Shore, Md (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

MOTHER | FATHER
12. Name Gibson
13. Birthplace Eastern Shore, Md.
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant David Phillips
(b) Address 550 Mc Mechen St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 9, 1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore, Md.

18 (a) Funeral director Mrs. George W. Haulard
(b) Address 1631 Druid Hill Ave

MAY 9 - 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 1947, at 6:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 6 1947 to May 6 1947, and that I last saw her alive on May 6 1947.

Immediate cause of death Congestive Heart Failure — Duration 48 hrs.

Due to Cardiovascular Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cardiac hypertrophy, Renal sclerosis.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stafford P. Summerden M. D.
Address 1309 Druid Hill Ave Date signed 5-6-47

X

G51501

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1146 Registered No. G51501

A42311

1. PLACE OF DEATH:
(a) Baltimore City, Mary
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 408 S. Caroline St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Wiggins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: black | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-7-45

8. AGE: Years: 1 year | Months: 4 | Days: 29 | If less than one day ..... hr. ..... min.

9. Birthplace D. C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Randolph Wiggins
13. Birthplace Md.

MOTHER
14. Maiden Name Betty
15. Birthplace Va.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 9-47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cem
Location Brooklyn, Md.

18 (a) Funeral director Elroy B. Wilson
(b) Address 1010 Baltimore ave

19 (a) MAY 9 1947 (Date received by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May - 6 - 1947 at 6 20 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-22- 1946, to 5-6- 1947, and that I last saw him alive on 5-6- 1947

Immediate cause of death: Respiratory failure — Duration: 12 hrs.
Due to:
Due to: Anemia Malnutrition — 6 Mo over
Other Conditions: Idiopathic Steatorrhea
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert J. Sheldon M D
Address Date signed 5/6/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G51502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

Registered No. G51502

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3702 Eldorado Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3702 Eldorado Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME David Blumenthal

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bertha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 73 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER 12. Name Harry
13. Birthplace Russia

MOTHER 14. Maiden Name Leba
15. Birthplace Russia

16 (a) Informant Bertha Blumenthal
(b) Address 3702 Eldorado ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-11-47 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Fernwood Belf Rd.

18 (a) Funeral director Jack Levy Inc
(b) Address 1439 E Baltimore St

19 (a) MAY 9 - 1947 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-8-1947 at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946 to 5/8 1947.
and that I last saw h[illegible] alive on 5/8 1947.

Immediate cause of death: Carcinoma of the Prostate — Duration: 2 yrs

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. I. Lamberti
Address 2128 W. Fayette Date signed 5/9/47

X

G51503

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

✓ G51503 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1013 Fawn St.
(c) Hospital or institution: 3/

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1013 Fawn St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Francesco Franco

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	215-05-6841

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21 1882

8. AGE: Years	Months	Days	If less than one day
65		16	hr. min.

9. Birthplace Montorio Al Vomano Italy
(Town, county, and state)
10. Usual Occupation Elevator Operator
11. Industry or business Mc Cormick Co.

FATHER
12. Name ?
13. Birthplace Italy

MOTHER
14. Maiden Name ?
15. Birthplace Italy

16 (a) Informant Frederick Petrella
(b) Address 1017 Stiles St.

17 (a) Burial (b) Date thereof May 10 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery of ~~Xxxxxxx~~ Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Vecchia
(b) Address 52 N. Morley St.

MAY 9 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7, 1947, at 2:15 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 11, 1942 to May 7, 1947, and that I last saw him alive on May 5, 1947.

Immediate cause of death	Duration
Coronary Occlusion	10 to 15 min.
Due to Coronary Sclerosis	5 years
Myocardial Damage	5 years
Due to Arteriosclerosis	Unknown
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Philibert Antizjani M. D.
Address 2942 E. Fayette St. Date signed 5/9/47

X

G51504

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G51504 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2502 Keyworth Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2502 Keyworth Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Moses Benjamin Schwartz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
69			hr. min.

9. Birthplace Lith (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Alex Lith
13. Birthplace

MOTHER
14. Maiden Name Esther Lith
15. Birthplace

16 (a) Informant Mary Schwartz
(b) Address 2502 Keyworth Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-9-47 (month) (day) (year)
(c) Cemetery or crematory Hebrew Young Men
Location Woodsor Mud Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 1409 E Balto St

MAY 9 - 1947 (Date rec'd by registrar) (b) Huntingtor Williams Mgr

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-8-1947, at 10:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 16, 1947 to 5/8 1947 and that I last saw him alive on 5/8, 1947.

Immediate cause of death: Arteriosclerotic Cardiovascular Disease with Hypertension — Duration 3 yrs.
Due to
Due to
Other Conditions Coronary Occlusion — 30 Mos.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. A. Snooman M.D.
Address 1194 Calvert St. Date signed 5/9/47

X

G5 I505

BALTIMORE CITY HEALTH DEPARTMENT

BC# D77683 CERTIFICATE OF DEATH 159

✓ G5 I505 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2026 W. Fayette St.
(c) Hospital or institution: Bon Secours
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 226 Bouldin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Walker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/5/47

8. AGE: Years | Months | Days 3 | If less than one day 20 hr. min.

9. Birthplace Bon Secours Hospital
(Town, county, and state)

10. Usual Occupation Baltimore Md.

11. Industry or business

FATHER
12. Name Charles X. Walker
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Dorothy L. Bowling
15. Birthplace Baltimore Md.

16 (a) Informant Charles X. Walker
(b) Address 226 Bouldin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/9/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Martin Fahey & Sons
(b) Address 1827 N. North Ave.

19 (a) (Date) MAY 9 1947 (b) registrar Contractor for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 1947, at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 5 1947 to May 8 1947, and that I last saw her alive on May 8 1947

Immediate cause of death Prematurity

Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter B. Langer, M.D.
Address Bon Secours Hospital Date signed 5/8/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G51506

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 822 S. Port Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 822 S. Port Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY W. NEELS

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: M
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Minnie S. Neels
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept. 27, 186

8. AGE: Years 82 | Months 7 | Days 11 10 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: Tank Hand, Amer. Ice
11. Industry or business: retired 17 yrs

FATHER
12. Name: ? Neels
13. Birthplace: Germany

MOTHER
14. Maiden Name: Caroline ?
15. Birthplace: Germany

16 (a) Informant: Edward W. Neels - son
(b) Address: 822 S. Port Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/10/47 (month) (day) (year)
(c) Cemetery or crematory: Mount Carmel Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

MAY 9 - 1947 (Date rec'd by registrar) (b) Thurlington Williamson, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1947, at 12 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 3 1947 to May 7 1947 and that I last saw him alive on May 2 1947.

	Duration
Immediate cause of death: Coronary Thrombosis	3 days
Due to: Coronary Sclerosis -	2
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Edward W. Neels
Address: 822 E. Fayette Date signed: 5/7/47 M.D.

G51507

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G51507
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6215 York Rd (If rural give location)
(e) Citizen of foreign country (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS DAVID CRONE

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) September 29, 1877

8. AGE: Years 69 | Months 7 | Days 9 | If less than one day hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: Carpenter
11. Industry or business

FATHER
12. Name: Jacob Crone
13. Birthplace: Penna.

MOTHER
14. Maiden Name: Mary Davis
15. Birthplace: Baltimore, Maryland

16 (a) Informant: Mrs. Mary L. Benhoff - si
(b) Address: 6215 York Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/10/47 (month) (day) (year)
(c) Cemetery or crematory: Mt. Carmel
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) MAY 9 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1947, at 12 05 P.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Coronary artery disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 5-7-47

C51508

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. C51508

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1427-W. Fayette Street.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1427 W. Fayette Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL WINGATE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Unknown (Town, county, and state)

10. Usual Occupation Unknown

11. Industry or business

FATHER
12. Name
13. Birthplace Unknown

MOTHER
14. Maiden Name
15. Birthplace Unknown

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/10/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Frederick Rd & Alb Rd

18 (a) Funeral director Ellsworth Amment
(b) Address 3911 Liberty Heights Ave.

19 (a) Filed by (b) Registrar

MAY 9 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27, 1947, at M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary thrombosis
Myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 4-28-47

V2 191

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51509

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a ✓

Registered No. G51509

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5116 STAFFORD RD
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 44 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 5116 STAFFORD RD. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME BERTHA L. REMMEL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOWED

6 (b) Name of husband or wife ROBERT REMMEL
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 24 1871

8. AGE: Years	Months	Days	If less than one day
75	8	13	hr. min.

9. Birthplace GERMANY (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER 12. Name KARL DEIS
13. Birthplace GERMANY

MOTHER 14. Maiden Name CAROLINE REININGHOUSE
15. Birthplace GERMANY

16 (a) Informant JOHN W. LEHMEYER
(b) Address 5116 STAFFORD RD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 5 10 '47 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location BALTIMORE

18 (a) Funeral director Bailey Slade
(b) Address 4907 Harford Road

19 MAY 9 - 1947 (Date rec'd by Registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1947, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 3 1947 to May 7 1947 and that I last saw h[illegible] alive on May 3 1947

Immediate cause of death
Coronary Occlusion

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
7 hr

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. M. Collins
Address 332 W Fredrick Ave Date signed May 9 1947

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

651510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. 651510

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2620 Kirk Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Ellen M. Bacon

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband ~~or wife~~: Joseph E. Bacon
6 (c) If alive, give age: dead years

7. Birth date of deceased (mo., day, yr.) Sept. 21, 1882

8. AGE: Years 64 | Months 7 | Days 17 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Thomas Murphy
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Murphy (also)
15. Birthplace Ireland

16 (a) Informant Hospital records
(b) Address Union Memorial Hosp.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/12/47. (month) (day) (year)

(c) Cemetery or crematory Jew Cathedral
Location Edmondson Ave Balto.

18 (a) Funeral director George Rutts Inc
(b) Address 1725 Edmondson Ave

19 (Filed) MAY 9 - 1947 (Registrar's signature) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 1947, at 8:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 7 1947 to May 8 1947, and that I last saw her alive on May 8 1947.

Immediate cause of death	Duration
Subdural hematoma	1 day
Due to	
Due to	
Other Conditions: Fractured skull	1 day
Brain concussion	1 day

(Include pregnancy within 3 months of death)

Date of operation May 7, 1947
Major findings of operation: Subdural hematoma right
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 9/5
(a) Accident, suicide, or homicide accidental
(b) Date of occurrence May 7, 1947, at 5 PM P M
(c) Where did injury occur? 2620 Kirk Ave (City or town) Baltimore (County) Md. (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? No
(e) Means of injury fell down steps.

23. Signature Ernest V. deMoss M. D.
Address Union Memorial Hospital Date signed 5-8-47
For E. V. deMoss, by Howard J. Williams, M.D.

VS 150

G51511

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G51511

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 23 E. Fort Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 23 E. Fort Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LILLIAN B. ARNAL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife William G. Arnal
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23rd, 1881

8. AGE: Years	Months	Days	If less than one day
65	11	17	15 hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Wm. Steigers
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary H. Biaset
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. John R. Gritz
(b) Address 2048 Robb St.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 5/10/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location 3310 Taylor Ave.

18 (a) Funeral director Lasagna Funeral Home
(b) Address 740 Belair Road

19 (Date received by registrar) MAY 9 - 1947 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7th 1947, at 7:45 P.

21. I certify that death occurred on the date above stated; that I attended deceased from April 4 1947, to May 7 1947, and that I last saw him alive on May 6 1947.

Immediate cause of death: Chronic nephritis — Duration

Due to —

Due to —

Other Conditions Arteriosclerosis, hypertension (Include pregnancy within 3 months of death)

Date of operation —

Major findings of operations: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature John E. Schwenck, M.D.
Address 1337 E. Chase St. Date signed 5/8/47

G51512

514004

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

56E

Registered No. G51512

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Washington D.C. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1409 Monroe St. N.W. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Calvert

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-11-80

8. AGE: Years 67 | Months 1 | Days 28 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name James E Calvert
13. Birthplace Va

MOTHER 14. Maiden Name Sally Walton
15. Birthplace Va

16 (a) Informant Record
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 5-9-47 (month) (day) (year)
(c) Cemetery or crematory
Location Wash. D.C.

18 (a) Funeral director Joseph Gawler Sons
(b) Address Wash. D.C.

19 (a) MAY 9 - 1947 (Date received by registrar) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION A

20. DATE OF DEATH May - 9 1947, at 3.05 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 22 1947 to May - 9 1947, and that I last saw him alive on May 9 1947.

	Duration
Immediate cause of death Vascular collapse	
Due to operation for pituitary tumor	1 day
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 4-25-47

Major findings of operation: Chromophobe tumor of pituitary

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles W. Burkland M. D.
Address Johns Hopkins Hospital Date signed 5-9-47

VS 150

G51513

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G51513

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3522 Edmondson Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3522 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Holmes

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: late John W. Holmes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 26, 1871.

8. AGE: Years 75 | Months 7 | Days 12 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Asbury W. Hartleve
13. Birthplace Md.

MOTHER
14. Maiden Name Jane Dyer
15. Birthplace Md.

16 (a) Informant Mrs. Hazel V. Burns
(b) Address 3522 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 12/47. (month) (day) (year)
(c) Cemetery or crematory Louden Park
Location 3801 Frederick Rd.

18 (a) Funeral director Harry A. Winkler
(b) Address 4101 Edmondson Ave.

19 (a) MAY 9 — 1947 by reg Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8/47. 19 , at 5 4 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1946 to May 8 1947
and that I last saw her alive on May 8 1947.

Immediate cause of death Chronic Myocarditis — Duration 1 Year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. A. Lacy, M.D.
Address 3517 Edmondson Ave. Date signed May 9, 1947
M. D.

G51514

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G51514

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3539 Liberty Heights Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3539 Liberty Heights Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER E. SMITH

3 (b) If veteran, name war: --

3 (c) Social Security Account No. 216-01-0017A

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Una I. Smith (nee Hafele) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11, 1877

8. AGE: Years	Months	Days	If less than one day
69	11	27	hr. min.

9. Birthplace Buffalo, N. Y.
(Town, county, and state)
10. Usual Occupation Hecht Bros. Co.
11. Industry or business Furniture

FATHER
12. Name Peter Smith
13. Birthplace Unknown

MOTHER
14. Maiden Name Helen Young
15. Birthplace Unknown

16 (a) Informant Mrs. Una I. Smith
(b) Address 3539 Liberty Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/12/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 MAY 9 - 1947 (Date rec'd by registrar) (Signature) Washington Hollinger, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8, 1947, at 7:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 30 1947, to May 8 1947, and that I last saw him alive on May 7 1947

Immediate cause of death	Duration
(a) Cerebral Hemorrhage	5/8/47
Due to (b) Chr. Myocarditis	1905
Due to (c) Ch. Interstitial Nephritis	1945
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Paul E. Brown, M.D.
Address 1663 W. Lexington St. Date signed 5/9/47

VS 150

G51515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G51515

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MARYLAND GENERAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Granite
(If outside city or town limits, write RURAL and give town)
(d) Street No. Offutt Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT J. MURRAY

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Katherine E. Murray
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 24, 1872

8. AGE: Years 74 | Months 7 | Days 25 | If less than one day ... hr. ... min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation Doctor of Medicine

11. Industry or business

FATHER
12. Name Frederick T. Murray
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Christina Frash
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Katherine E. Murray
(b) Address Granite, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/12/47 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 MAY 9 - 1947 (Date rec'd by registrar) Huntington Wilkinson, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/9 1947, at 12 05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/8 1947 to 5/9 1947, and that I last saw h.IM alive on 5/8 1947.

Immediate cause of death HYPERTENSIVE CARDIOVASCULAR DISEASE & DECOMPENSATION — Duration 6½ Hrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles W. Stewart, Jr. M.D.
Address MD. GEN. HOSP. Date signed 5/9/47

VS 150

G51516

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 937

✓ G51516 Registered No.

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution:
St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 28 Cedarwood Road (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME (Bernhard H.) Bernard H. Drushler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-13-64

8. AGE: Years	Months	Days	If less than one day
82	8	25	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Grocery Store

FATHER 12. Name Michael Drushler

FATHER 13. Birthplace Pa.

MOTHER 14. Maiden Name Anna Sibel

MOTHER 15. Birthplace Pa.

16 (a) Informant Mrs. Charles A. Shere

(b) Address 28 Cedarwood Rd. Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/12/47 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet Cathedral

Location Old Frederick Rd.

18 (a) Funeral director Elmer H. Conklin & Son

(b) Address 924 E. Eager St.

19 MAY 9 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 May 1947, at 8-55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/27/47 1947, to 5/8 1947, and that I last saw h alive on 5/8 1947.

Immediate cause of death	Duration
Uraemia	
Due to Urinary obstruction	
Due to Prostatic hypertrophy	
Other Conditions Arteriosclerotic heart disease	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Esther J. Owen

Address Mt. Loyola Hall Date signed 5/9/47

VS 150

137a

Reserve #6 #6 ✓ G51517

BALTIMORE CITY HEALTH DEPARTMENT over 183 Registered No. G51517

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street
(c) Hospital or institution: Found Dead #5 Pratt St.
(d) Length of stay in hospital or inst. (yrs., mos., or days) ?
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Norway (b) County
(c) City or town Bergen
(If outside city or town limits, write RURAL and give town)
(d) Street No. Bondre Greigssmug 6
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Norway

3 (a) **FULL NAME** UNKNOWN Odd Thowsen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Valborg Olivia Thowsen 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 22, 1920

8. AGE: Years	Months	Days	If less than one day
26 27	8	2	hr. min.

9. Birthplace Norway (Town, county, and state)
10. Usual Occupation Mate on
11. Industry or business S.S. "Francis A. Retaka"

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Ingerid ?
15. Birthplace Bergen, Norway

16 (a) Informant Balto. City Police Dept.
(b) Address Baltimore, Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY MAY 8 1947
18 (a) Funeral director Commissioner of Health
(b) Address
MAY 9 - 1947 Thomas J. Williams M.D.
(Date rec'd by Registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 1947, at 1.30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury found 5/25 at 4/1 12 P.M.
(b) Where did injury occur? Pier 5 Pratt St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? ?
(d) Means of injury found drowned

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 4/26/47

G51518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 136

Registered No. G51518

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address A
(c) Hospital or institution: Md. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 1211 Linden ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years	Months	Days	If less than one day
43			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School MAY 7 1947

18 (a) Funeral director Commissioner of Health
(b) Address

MAY 9 - 1947 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/26 1947, at 9 20 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to Live death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lung abscess

Due to Pulmonary tuberculosis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D. (Medical Examiner)
Date signed 4-28-47

G51519

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Register's No. G51519

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4731 Alhambra Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4731 Alhambra Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amanda E Nolan

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Frank Nolan
6 (c) If alive, give age , years

7. Birth date of deceased (mo., day, yr.) Nov 29th 1872

8. AGE: Years	Months	Days	If less than one day
74	5	9	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name Charles Kelly
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Fisher
15. Birthplace Md.

16 (a) Informant Ralph P. Dolby
(b) Address 1217 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/12/47 (month) (day) (year)
(c) Cemetery or crematory Pinelawn Md
Location Baltimore

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 MAY 10 1947 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8th 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1946 to May 8 1947 and that I last saw h Er alive on May 1 1947.

Immediate cause of death	Duration
Coronary Occlusion	20 min
Due to Coronary Arteriosclerosis	6 mo
Due to Coronary Arteriosclerosis	6 mo
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas F. Mintz M. D.
Address 532 E 22nd St Date signed 5/9/47

VS 150

X

G51520

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

CM. 110392

Registered No. G51520

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 3Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1130 Boura Ct.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mills George

3 (b) If veteran, name war: W

3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 15-1879

8. AGE: Years	Months	Days	If less than one day
67	6	21	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Mills
13. Birthplace MD.

MOTHER
14. Maiden Name Laura Winters
15. Birthplace Tenn.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/10/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St

19 MAY 10 1947 Huntington Williams M.D.
(Signature and title of local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 1947, at 1.50PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 3 1947, to May 6 1947, and that I last saw h. alive on May 6 1947

Immediate cause of death: Severe gastritis & emphysema

Duration

Due to:

Due to:

Other Conditions: Bronchopneumonia, hemiation
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: Gastritis & Emphysema

of autopsy: Bronchopneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Doyle Waldron M.D.

Address B. C. H. Date signed 5/10/47

116

G51521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G51521

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3623 Kimble Road
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3623 Kimble Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roland Franklin Forlifer

3 (b) If veteran, name war: W

3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Married

6 (b) Name of husband or wife Victoria M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17, 1894

8. AGE: Years	Months	Days	If less than one day
52	6	21	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Health Club
11. Industry or business

FATHER
12. Name William Forlifer
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mary Eckert
15. Birthplace Baltimore, Maryland

16 (a) Informant Victoria M. Forlifer
(b) Address 3623 Kimble Road

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 5/10/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 MAY 10 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8, 1947, at 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to May 8 1947 and that I last saw him alive on May 8 1947

Immediate cause of death: Cerebral Hemorrhage — Duration: 8 hrs.
Due to Chr. Hypertension — 5 years
Due to Chr. Nephritis — 5 years
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature J. S. Harding
Address 4810 Belair Rd. Date signed 5/9/47

VS 150

G51522

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered Number G51522

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2615 Kirk Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2615 Kirk Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Rose Scott

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 1114

4. Sex	5. Color or race	6 (a) Single, married, ~~widowed, or divorced~~
Female	White	Married

6 (b) Name of husband Arthur R. Scott
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 21st 1900

8. AGE: Years	Months	Days	If less than one day
46	6	16	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name George E. Stortz
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Rosa Beck
15. Birthplace Balto. Md.

16 (a) Informant Arthur R. Scott
(b) Address 2615 Kirk Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 5/10/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ National Memorial Park
Location Falls Church Va.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 ~~MAY 10 1947~~ (Date received by Registrar)
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7th 1947, at 1:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1 1945 to May 7 1947.
and that I last saw her alive on May 6 1947

Immediate cause of death	Duration
Carcinomas of uterus	3 years
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George Dunavan M.D.
Address 4308 Harford Date signed 5/9/47

G51523

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G51523

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2401 Annapolis Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2401 Annapolis Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eva Pearl Seifert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Wm. Seifert

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) July 13, 1904

8. AGE: Years	Months	Days	If less than one day
42	9	25	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Oliver S. Draney
13. Birthplace Md.

MOTHER
14. Maiden Name Emma Wagner
15. Birthplace Germany

16 (a) Informant William Seifert
(b) Address 2401 Annapolis Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 12-1947 (month) (day) (year)
(c) Cemetery or crematory Friendship
Location A.A. County, Md

18 (a) Funeral director Pratt & B.M. Walton
(b) Address Pratt & Tucker Sts

19 MAY 10 1947 Huntington Williams, M.D.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/8 1947 at 8:45 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial hypertrophy and degeneration

~~Due to~~ Coronary arteriosclerosis

Pulmonary edema

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D. Medical Examiner.
Date signed 5-9-47

X

G51524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G51524

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) Daa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1708 Lawrence St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Maora Hill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, (widowed,) or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 70 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Amherst Co. Va (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Randell Hill
13. Birthplace Va.

MOTHER
14. Maiden Name unknown
15. Birthplace Va.

16 (a) Informant John Hill
(b) Address 1708 Lawrence St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/12/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location West Pork. Balto. Md

18 (a) Funeral director Metropolitan Funeral Homes
(b) Address 927 N. Mount St. Balto

19 (a) MAY 10 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 1947, at 2 A M

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D. Medical Examiner
Date signed 5-9-47

VS 151

G51525

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. G51525

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 527 S. Lakewood ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul Bochs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M.

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife. Gertrude

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/11/68

8. AGE: Years 79 | Months 2 | Days 27 | If less than one day ____ hr. ____ min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs Christina Sletzer
(b) Address 527 S Lakewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/12/47 (month) (day) (year)
(c) Cemetery or crematory Lakewood
Location Sayla Ave Balto

18 (a) Funeral director Selig + Zeder Co
(b) Address 403 S. Arch St

19 (a) MAY 10 1947 (Date received by Registrar) (b) Huntington Williams Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8, 1947, at 10 A.M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mc Lean M.D.
Medical Examiner.
Date signed 5-8-47

G51526

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered G51526

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct ago is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto City Hospital 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. City Jail 2147 E. Castle St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Feller - Louis John Kreipl

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 23 - 1881.

8. AGE: Years	Months	Days	If less than one day
(65) 65	5	15	hr. min.

9. Birthplace Austria (Town, county, and state)
10. Usual Occupation Cabinet Worker
11. Industry or business

FATHER
12. Name Frank Kreipl
13. Birthplace Austria

MOTHER
14. Maiden Name Mary Pimmer
15. Birthplace Austria

16 (a) Informant Mary Kreipl
(b) Address 214 N. Castle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 12 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Belair Road

18 (a) Funeral director Libby & Zeiler Inc.
(b) Address 703 South Wolfe St

19 (a) MAY 10 1947 (b) Hunter for Williams, M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/8 1947, at 4:30 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fracture of Skull & Intracranial Hemorrhage

Due to

Other Conditions Pulmonary tuberculosis Chronic Adhesive Arachnoiditis
(Include pregnancy within 3 months of death) Arachnoiditis

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-11-47 at 3:45 P.M. 4/2
(b) Where did injury occur? 622 W. Fayette St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Fall from stairway to ground

23. Signature [signature] M.D. Medical Examiner.
Date signed 5-9-47

VS 191

X

G51527

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

Registered No. G51527

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 694 w Mulberry St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 694 W. Mulberry
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George E. Jackson

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1888

8. AGE: Years	Months	Days	If less than one day
59			hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name George E. Jackson
13. Birthplace Md

MOTHER 14. Maiden Name Mary E. Ross
15. Birthplace Md

16 (a) Informant Herman Jackson
(b) Address 1119 Caldwell St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/11/47 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director James A. Hayes
(b) Address 1442 W. Hill St

19 (a) MAY 10 1947 (If buried or cremated by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1947, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to May 7 1947 and that I last saw him alive on May 7 1947.

Immediate cause of death	Duration
Cardio Renal Disease	5 mo
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eric A. Johnson, M. D.
Address 2329 Guilford Ave Date signed May 9 1947

VS 150

G51528

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G51528

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 911 Warwick Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 911 Warwick Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John A. Smith.

3 (b) If veteran, name war: None.
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Ethel M. Smith.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 13-1880

8. AGE: Years: 66 | Months: 6 | Days: 24 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Electrician.

11. Industry or business B. & O. R.R.

FATHER
12. Name Wm. Smith.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Frances Wallace.
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Ethel M. Smith.
(b) Address 911 Warwick Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May (month) (day) 47 (year)
(c) Cemetery or crematory Mount Olivet Cem.
Location Baltimore, Md.

18 (a) Funeral director Charles J. Schurb.
(b) Address 3512 Frederick Ave.

MAY 10 1947 Washington Williams, M.D. Registrar
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8th: 1947 at 7.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/23 1947, to 5/8 1947 and that I last saw him alive on 5/7 1947.

Immediate cause of death: Myocardial Insufficiency — Duration: 3 weeks.
Due to: Coronary sclerosis — 10 mo.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence or at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert A. Reiter
Address 340 E. Madison Ave. Date signed 5/9/47

VS 180

X

G51529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G51529

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ of Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 wks
(e) Length of stay in Baltimore (yrs., mos., or days) 4 wks

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Parkton (If outside city or town limits, write RURAL and give town)
(d) Street No. Mt. Carmel Rd (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME ARTHUR W. GOELLER

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: m

6 (b) Name of husband or wife: Frances Grace Foote
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Apr. 28, 1878

8. AGE: Years 69 | Months — | Days 12 | If less than one day: hr. min.

9. Birthplace Newark, N. J. (Town, county, and state)
10. Usual Occupation Dept. Clerk retired
11. Industry or business Western Electric

FATHER
12. Name Wm. Goeller
13. Birthplace Germany

MOTHER
14. Maiden Name Yuhnedown
15. Birthplace

16 (a) Informant Mr. Arthur B. Goeller
(b) Address Parkton Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-12-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Methodist
Location Mt. Carmel, Balto. Co. Md.

18 (a) Funeral director J. Wm. Brooks
(b) Address Parkton, Md.

19 (a) MAY 10 1947 (Date rec'd by registrar) Huntingtown for Williamsville, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 MAY 1947 at 6:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 15 APRIL 1947 to 10 MAY 1947, and that I last saw h IM alive on 9 MAY 1947.

Immediate cause of death	Duration
PULMONARY INFARCTION	
ACUTE CARDIAC FAILURE	
Due to FRACTURE FEMUR	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation NONE
Major findings of operation:
of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 4-16-47 at 2:15 P M
(c) Where did injury occur? Mt. Carmel Rd (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? no
(e) Means of injury Jumping on rug + fell

23. Signature Robert E. Bassett M. D.
Address Univ. Hospital Date signed

Howard J. Mullin, M.D.

G51530

CWK-110506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No. G51530

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 Min.
57- 5- 11-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Edgewater-Middle River
(If outside city or town limits, write RURAL and give town)
(d) Street No. 452 Edgewater Apartments
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Lillian Harrison Nece

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 26-1889

8. AGE: Years	Months	Days	If less than one day
57	5	11	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Howard J. Smith
13. Birthplace Maryland

MOTHER
14. Maiden Name Laura Nece
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 5-10-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Mary's Hampden
Location Baltimore

18 (a) Funeral director Frank H. Leitz
(b) Address 814 N 36 St

MAY 10 1947 Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 19 47 at 11:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 7 1947 to May 7 1947, and that I last saw her alive on May 7 1947.

Immediate cause of death	Duration
Cardiac failure	
Due to Coronary occlusion	
Due to	
Other Conditions Pulmonary congestion. (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation

of autopsy Coronary occlusion. Pulmonary congestion and edema. Enlarged Heart

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Doyle Waldron M.D.
Address B. C. H. Date signed 5/8/47

VS 150

G51531

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1084

Registered No. G51531

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 519 E. 41 street
(c) Hospital or institution: 41

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 519 E. 41 Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nettie E. Thompson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: George S. Thompson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25-1871

8. AGE: Years 75 | Months 76 | Days 11 | 16 | If less than one day: 5 hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER
12. Name John Kerr
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Anne Marie Hamilton
15. Birthplace Balto Md.

16 (a) Informant Leroy K. Thompson
(b) Address 2950 E. Mac. Arthur Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May-12-1947 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto. Md.

18 (a) Funeral director Ingram & Lefer
(b) Address 1600 W. North Ave.

19 MAY 10 1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9. 1947 at 3-45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1947, to May 9. 1947, and that I last saw her alive on May 8, 1947.

Immediate cause of death: Myocardial insufficiency — Duration: 7,

Due to: Lobar pneumonia — 5 days.

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature J. Willis Guyton M.D.
Address 3963 Greenmount Ave Signed 5/10/47

VS 150

X

G51532

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G51532

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1314 Division st
(c) Hospital or institution: Provident
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 802 W Lexington (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** George Lancaster

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/4/1861

8. AGE: Years 86 | Months 12 | Days 3 | If less than one day hr. min.

9. Birthplace St. Mary's County (Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. Lena Lancaster
(b) Address 802 W. Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-12-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location E. A. Co. Md.

18 (a) Funeral director Mc Francis A. Kennedy
(b) Address 578 W. Biddle st.

19 (a) MAY 10 1947 Huntington Williams, M.D. Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/7 1947, at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/16 1946 to 5/7 1947, and that I last saw h[illegible] alive on 5/7 1947.

Immediate cause of death: Congestive [illegible]
Antonio S. Tenn..

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. K. Adams
Address 1222½ Caroline Date signed 5-8-47

VS 150

G51533

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G51533

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 926 N. Calhoun Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MATILDA SAVOY

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/4/1899

8. AGE: Years	Months	Days	If less than one day
47	7	4	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Thomas Hampton
13. Birthplace Md

MOTHER
14. Maiden Name Agnes Capper
15. Birthplace Md

16 (a) Informant Evelyn Savoy
(b) Address 1002 W. Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/12/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md

18 (a) Funeral director Geo. G. Kelson
(b) Address 1303 Pleasant St

19 (a) MAY 10 1947 (Date rec'd by Registrar) Huntington Williams, M.D. (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8, 1947, at 6 a. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial hypertrophy and degeneration

~~Due to~~ Acute pulmonary edema.

Syphilitic aortitis.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. (Medical Examiner)
Date signed 5-8-47

G51534

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

G51534 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1345 N. Carey Ln
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 101 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1345 N Carey Ln (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Thomas

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: John W Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1846

8. AGE: Years 101 | Months | Days 2 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Jake Broom
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Thomas
15. Birthplace Md.

16 (a) Informant Carrie Cole
(b) Address 1345 N Carey Ln

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/10/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. H. Nelson
(b) Address 1303 Pressman St

19 MAY 10 1947 (b) Thurlington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 1947, at 11.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 16 1946, to May 8 1947, and that I last saw her alive on May 8 1947.

Immediate cause of death Chronic Valvular Heart Disease — Duration 2 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E William Frey
Address 928 Penna Ave Date signed 5/10/47

VS 150

X

G51535

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G51535 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 51 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 823 W. Saratoga St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME David Brown

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-01-6950

4. Sex Male | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Dorothy Brown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 1896

8. AGE: Years 50 | Months 5 | Days 1 | If less than one day hr. min. 48 | 26

9. Birthplace Balto, Md.
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name Julius Brown
13. Birthplace Balto - Md

MOTHER
14. Maiden Name Mary Barlow
15. Birthplace Balto Md

16 (a) Informant Mrs. Dorothy Brown
(b) Address 823 W. Saratoga St. Apt. 10

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-12-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winans

18 (a) Funeral director Mrs. Kate R. Williams
(b) Address 322 N. Schroeder St.

19 (a) [illegible] Huntington Williams M.D. Registrar

MAY 10 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 1947, at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-7 1947 to 5-8 1947, and that I last saw h[illegible] alive on 5-8 1947.

	Duration
Immediate cause of death: Respiratory Failure	11 hrs
Due to Subarachnoid Hem.	18 hrs
Due to Hypertension	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William D. Gentry M.D.
Address Mercy Hosp. Date signed 5-9-47

VS 150

correct age is especially important. Physicians: please write the ... Every item of information should be carefully supplied. The ... the causes of death clearly and legibly.

G51536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G51536

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 216 Ridgewood Road
(c) Hospital or institution: home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) abt 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town City of Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 216 Ridgewood Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Etta Legge Galloway

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced (husband): Widowed

6 (b) Name of husband or wife: Aquilla Galloway
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Mar. 13 - 1870

8. AGE: Years 77 | Months 1 | Days 26 | If less than one day hr. min.

9. Birthplace Kent Island-
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name Col. John Henry C. Legge
13. Birthplace Prob. Kent Island

MOTHER
14. Maiden Name Marietta Cook
15. Birthplace Prob. Kent Island

16 (a) Informant Mrs. Clarence M. Elder (Daughter)
(b) Address 219 Williams St.-Staunton, Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 - 12 - 1947 (month) (day) (year)

(c) Cemetery or crematory Thornrose
Location Staunton-Va.

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) (Undertaker's address) (WOODEN SUC.) 109 W. NORTH AVENUE

19 (a) MAY 10 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 1947 at 8 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1946 to May 9 1947 and that I last saw h[illegible] alive on May 9 1947

Immediate cause of death	Duration
Acute Pulmonary Edema	4 hours
Due to Acute Cardiac Dilatation	—
Due to Arterio-Sclerosis	about 16 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation —
of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature H. L. Kemp
Address Waterworth, Md. signed May 9 1947

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S51537

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered S51537

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd and Calvert.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 6½ Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town ESSEX
(If outside city or town limits, write RURAL and give town)
(d) Street No. 33 WAWMETER DR. (MIDDLE RIVER)
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME PETTEE, CLAUDE

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: Evelyn E. Pettee
6 (c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): May 7, 1889

8. AGE: Years: 58 | Months: 0 | Days: 3 | If less than one day: ____hr. ____min.

9. Birthplace: Plattville, Colo.
(Town, county, and state)

10. Usual Occupation: Electrician

11. Industry or business: Friese Company

FATHER
12. Name: Orrias K. Pettee
13. Birthplace: Colo.

MOTHER
14. Maiden Name: Anna B. Wyen
15. Birthplace: Colo.

16 (a) Informant: W.H. Pettee
(b) Address: 3609 Windsor Mill Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/12/47 (month) (day) (year)
(c) Cemetery or crematory: Levenon Church Cem.
Location: Alfanso, Virginia

18 (a) Funeral director: George W. Little
(b) Address: 2700 Edmondson Ave.

19 (Date received by registrar) MAY 10 1947 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MAY 10 1947, at 12:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-10 1947, to 5-10 1947, and that I last saw him alive on 5-10 1947.

Immediate cause of death	Duration
Cerebral Vascular Accident	2 hrs.
Due to: Malignant Hypertension	6 mos.
Due to: Arterio Sclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy: None.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Edward H. Jones Jr. M. D.
Address: Union Memorial Hosp. Date signed 5-10-47

VS 150

G51538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G51538

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1810 W. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emile Kolb

3 (b) If veteran, name war None
3 (c) Social Security Account No.

4 Sex Male | 5 Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary W. Kolb
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) 3-21-77

8. AGE: Years 70 | Months 1 | Days 17 | If less than one day — hr. — min.

9. Birthplace Maryland Galesville, (Town, county, and state)

10. Usual Occupation Ass't. Vice Pres.

11. Industry or business Maryland Casualty Co.

FATHER 12. Name John Kolb
13. Birthplace Md.

MOTHER 14. Maiden Name Caroline Kirchner
15. Birthplace Md.

16 (a) Informant Record
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/12/47 (month) (day) (year)

(c) Cemetery or crematory
Location Galesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date received by local registrar MAY 10 1947 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-8-47, at 4:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-5 1947, to 5-8 1947, and that I last saw h[illegible] alive on 5-8-1947

Immediate cause of death	Duration
Acute Myocardial Infarction	
Due to Coronary Occlusion	
Due to Coronary Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A.M. Knight M. D.
Address John Hopkins Hospital Date signed 5-8-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C51539

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C51539

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 717 Denison Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 717 Denison Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Brown L. Taylor

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-01-6050

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Marjorie D. Taylor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 24-1892

8. AGE: Years 55 | Months 1 | Days 15 | If less than one day hr. min.

9. Birthplace Harrisonburg Virginia (Town, county, and state)

10. Usual Occupation Filling Station Operator

11. Industry or business

FATHER
12. Name Joseph Taylor
13. Birthplace Virginia

MOTHER
14. Maiden Name Unknown
15. Birthplace Virginia

16 (a) Informant Mrs. Marjorie D. Taylor
(b) Address 717 Denison Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 12-1947 (month) (day) (year)
(c) Cemetery or crematory St. Mary's (Hampden)
Location Baltimore, Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (d) MAY 10 1947 Huntington Whitehurst, M.D. Address

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9- 1947, at 9:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/3 1947 to 5/9 1947 and that I last saw Him alive on 5/9/ 1947.

	Duration
Immediate cause of death Coronary Thrombosis -	5 min.
Due to Arteriosclerosis.	? -
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James E. Bogard M.D.
Address 1905 W. Baltimore St. Date signed 5/10/47.

V S 150

X

G51540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 82

Registered No. G51540

110317

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 7 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 28 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 206 Dolphin ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edna Eley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife Charles (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
45	?	?	hr. min.

9. Birthplace VA. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Thomas Hill
13. Birthplace VA.

MOTHER
14. Maiden Name Lenea
15. Birthplace VA.

16 (a) Informant Records, Balto. City Hospitals
(b) Address 4940 Eastern AVe.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 11 '47 (month) (day) (year)
(c) Cemetery or crematory Bella National Cem.
Location

18 (a) Funeral director Mrs. Pitt O. Elliott Dept
(b) Address 1129 N. Caroline St

19 MAY 10 1947 (Date filed in the city registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1947, at 11.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 30 1947, to May 7 1947, and that I last saw h er alive on May 7 1947.

Immediate cause of death	Duration
Respiratory Failure	Immediate
Due to Staphylococcus Bacteremia, Co-Cx,	1 week
cause undetermined	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Lawrence Lee Jr M.D.
Address Baltimore City Hosps Date signed 5-8-47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

File No. G51541 / 937 — Registered No. G51541

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton Ave & Wickens Ave
(c) Hospital or institution St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 11 S. Buchanan Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Millard Fillmore Carter

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Carrie V.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/28/1871

8. AGE: Years 75 | Months 4 | Days 10 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Judge
11. Industry or business

FATHER
12. Name Lorenzo Carter
13. Birthplace Md.

MOTHER
14. Maiden Name Virginia Johnson
15. Birthplace Md

16 (a) Informant Calvin Carter
(b) Address 150 Druid Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-10-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director George A. Farley
(b) Address Baltimore & Fayette St.

19 MAY 10 1947 (Date received by Registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 May 1947, at 10:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1st May 1947 to 7 May 1947, and that I last saw h[illegible] alive on 7 May 1947

Immediate cause of death	Duration
Cerebral Vascular Hemorrhage	6 days
Due to Hypertension, Cardio-	
Due to Vascular Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James Hamilton M.D.
Address St. Agnes Hosp. Date signed 7 May 47

VS 150

G51542 Amended

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 94a

Registered No. G51542

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 132 S Collington Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 132 S Collington (If rural give location)
(e) Citizen of foreign country? No (Yes or No). If yes, name country

3 (a) FULL NAME James B Herman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Lucy M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 6 1886

8. AGE: Years	Months	Days	If less than one day
61	3	2	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation
11. Industry or business Plasterer

FATHER
12. Name John Herman
13. Birthplace Md

MOTHER
14. Maiden Name Sarah Gaton
15. Birthplace Md

16 (a) Informant Jas B Herman
(b) Address 132 S Collington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-12-47 (month) (day) (year)
(c) Cemetery or crematory Odd Fellows
Location Balto Md

18 (a) Funeral director Geo C Farley
(b) Address Fulton & Fayette

19 MAY 10 1947 Registrar, Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-8 1947, at 8:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to 5-8 1947, and that I last saw alive on 5/7 1947.

Immediate cause of death Coronary Thrombosis — Duration

Due to

Due to

Other Conditions Pernicious Anemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alpha H Carruthers M. D.
Address 4209 Frederick Ave. Date signed 5/9/47

VS 130

051543 OH 17597

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

Registered 051543

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... correct age is especially important. Physicians: please write the... the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1118 Brewer St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1118 Brewer St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Evelyn Carter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3, 1947

8. AGE: Years | Months | Days: 5 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Carter
13. Birthplace Maryland

MOTHER
14. Maiden Name Bertha Williams
15. Birthplace South Carolina

16 (a) Informant James Carter
(b) Address 1118 Brewer St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-10-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna. Ave.

19 MAY 10 1947 (Date received by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 1947, at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 3 1947 to May 8 1947 and that I last saw h.r. alive on May 1947

Immediate cause of death: Cerebral Hemorrhage — Duration: 5 days

Due to: Birth daughter

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas W. Harris M. D.
Address 1824 W. Franklin St. Date signed 5-9-47

VS 150

X

G51544

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. G51544

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 35 S. Dallas St.
(c) Hospital or institution: 3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 35 S. Dallas St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margret L Chambers

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7 - 1861

8. AGE: Years	Months	Days	If less than one day
86			hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name David Chambers
13. Birthplace unknown

MOTHER
14. Maiden Name Annie Chambers
15. Birthplace Baltimore Md

16 (a) Informant Elizabeth Dashields
(b) Address 35 S. Dallas St

17 (a) Burial (b) Date thereof May 10, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location

18 (a) Funeral director Chas O. Wilson
(b) Address 1000 Bentley Ave

19 (a) MAY 10 1947 Huntington Williams, M.D.
(Date received by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1947, at 9:29 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 6 1947, to May 7 1947, and that I last saw h. alive on May 7 1947.

Immediate cause of death	Duration
Congestive Heart Failure	4 mo
Due to Hypertension	2 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. W. McDaniel M. D.
Address 807 N. Carlin Date signed 5-10-47

VS 150

X

G51545

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G51545 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd. St. & Guilford Ave.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) One
(e) Length of stay in Baltimore (~~yrs., mos.~~, or days) One

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Aberdeen
(If outside city or town limits, write RURAL and give town)
(d) Street No. —— (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jessie Hoff Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Alfred Wilson
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) June 9, 1871

8. AGE: Years	Months	Days	If less than one day
75	11	2	____ hr. ____ min.

9. Birthplace — , Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name James O. Hoff
13. Birthplace Maryland

MOTHER
14. Maiden Name Martha D. Arnold
15. Birthplace Maryland

16 (a) Informant Hospital records
(b) Address 33rd. St. & Guilford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 14 1947 (month) (day) (year)
(c) Cemetery or crematory Sparrows
Location Baltimore Md.

18 (a) Funeral director Murray Fleming & Sons
(b) Address Aberdeen Md.

19 (a) MAY 14 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11, 1947, at 8:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 9, 1947 to May 11, 1947 and that I last saw h. a. alive on May 11, 1947

Immediate cause of death	Duration
Coronary Thrombosis	18 hours
Due to Coronary arteriosclerosis	?
Due to	
Other Conditions Diabetes mellitus	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward H. Jones Jr. M. D.
Address Union Mem. Hosp. Date signed 5-11-47

94a

G51546

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 16

G51546

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1125 N. Gay St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Turner, Willie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ocie

6 (c) If alive, give age: 35 years

7. Birth date of deceased (mo., day, yr.) 5-4-09

8. AGE: Years 37 | Months | Days 3 | If less than one day: hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Sam Turner
13. Birthplace Virginia

MOTHER — 14. Maiden Name Hazel Dalentah
15. Birthplace Virginia

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 11-1947 (month) (day) (year)

(c) Cemetery or crematory Emporia, Va
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bennett Place ave

19 (a) MAY 1947 (b) Covington Williams, Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1947, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/26 1946 to 5/7 1947, and that I last saw h[illegible] alive on 5/7 1947.

	Duration
Immediate cause of death: Overwhelming tuberculosis of spine & peritoneum	20 mos.
Due to: Tbc of spine & peritoneum	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation Feb. 3, 1947

Major findings of operation: Extensive Tbc osteomyelitis of spine

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard A. Bragdon M.D. M. D.

Address Date signed

G51547

510006

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X ✓ 124 B

Registered No. G51547

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State..... (b) County.....
(c) City or town Kansas City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1207 Grand Ave.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Ralph Mowery

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-11-06

8. AGE: Years	Months	Days	If less than one day
40	10	29	hr. min.

9. Birthplace Ohio
(Town, county, and state)
10. Usual Occupation Theatrical Prod.
11. Industry or business

FATHER
12. Name Frank Mowery
13. Birthplace Ohio

MOTHER
14. Maiden Name Ella Smith
15. Birthplace Ohio

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 5/11/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Youngstown
Location Ohio

18 (a) Funeral director William Cook Inc.
(b) Address 127 E. Paul St.

19 (a) MAY 11 1947 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION A.

20. DATE OF DEATH May - 10 1947, at 4.25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb - 14 1947 to May - 10 1947 and that I last saw him alive on May - 10 1947.

	Duration
Immediate cause of death Cholemia	2 wks
* Azotemia	
Due to * Cirrhosis of liver	7 & 10's
Due to	
Other Conditions Hemorrhage from gastro-intestinal tract	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature Eugene Meyer M.D.
Address Johns Hopkins Hosp. Date signed May 10 1947

VS 150

X

G51548 B-C# B-76804

BALTIMORE CITY HEALTH DEPARTMENT ✓ G51548 Registered No.

CERTIFICATE OF DEATH 157E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. This correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St. & Linden Ave.
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 15 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1509 Linden Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Jacob Houseman

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 25, 1947

8. AGE: Years	Months	Days	If less than one day
		10	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business —

FATHER 12. Name Nathan H. Houseman
13. Birthplace Balto Md

MOTHER 14. Maiden Name May Grahame
15. Birthplace Penn

16 (a) Informant Nathan H. Houseman
(b) Address 1509 Linden Ave

17 (a) Burial (b) Date thereof 5-11-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Netgew Mt Carmel

18 (a) Funeral director Jack Lewis Inc
(b) Address 1409 E. Baltimore St

5 11 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 May 1947, at 2:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9 May 1947 to 10 May 1947 and that I last saw him alive on 9 May 1947

Immediate cause of death	Duration
Heart Failure	1 day
Due to Congenital Heart Disease	10 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. Allen Spiel M. D.
Address Md. Gen. Hosp Date signed May 11

VS 150

G51549

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G51549 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring Ave
(c) Hospital or institution: Levendale

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 10 x 710 Chester St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUIS APPLESTEIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 72 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER 12. Name unknown
13. Birthplace Russia

MOTHER 14. Maiden Name Esther
15. Birthplace Russia

16 (a) Informant Myer J Cohen
(b) Address 3217 Pickens Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof V 11-47 (month) (day) (year)
(c) Cemetery or crematory Hebrew Young Mens
Location Wyndson Mill Road

18 (a) Funeral director Jack Levin Inc
(b) Address 439 E Balto St

19 V 11 1947 (Date rec'd by registrar) Livingston Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-11 1947 at 7a P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-8 1947 to 5-11 1947 and that I last saw h[illegible] alive on 5-11 1947

Immediate cause of death: Chron. cardio-vascular disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry Nagel M. D.
Address Levindale Home Date signed V 11-47

VS 150

X

G51550

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46F

Registered No. G51550

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1705 N. Bentalou st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie Harris

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife Late Sol

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 66 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business House Wife

FATHER
12. Name Samuel Rosenberg
13. Birthplace Germany

MOTHER
14. Maiden Name Emma Rosenberg
15. Birthplace E. Germany

16 (a) Informant Mrs William Hamlet
(b) Address 1705 N. Bentalou st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 12/47 (month) (day) (year)

(c) Cemetery or crematory Ahabath Shalom Cemet
Location Edonnel st

18 (a) Funeral director Sol Levinson & Bro
(b) Address 1124-26 W. North ave

19 (a) Date 1947 registered [illegible] Washington Millimanville

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/8 1947, at 8:47 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/2 1947, to 5/8 1947, and that I last saw her alive on 5/8 1947

Immediate cause of death Myocardial failure — Duration

Due to Toxic myocarditis

Due to Carcinomatosis — over

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: Carcinomatosis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold M. Jordan M. D.
Address Date signed 5/9/47

X

G51551

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G51551

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 202 Mason Court
(c) Hospital or institution:
Womens Hospital 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 202 Mason Court
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Frances Sophie Reitz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife George Reitz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1, 1895

8. AGE: Years	Months	Days	If less than one day
52	4	8	hr. min.

9. Birthplace Baltimore Baltimore Co Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Robt. Milonicz
13. Birthplace Poland

MOTHER
14. Maiden Name Agnes Klinckt
15. Birthplace Poland

16 (a) Informant George Reitz
(b) Address 202 Mason Ct.

17 (a) Burial (b) Date thereof 5-13-47
(Burial, cremation, or removal) (month), (day) (year)
(c) Cemetery or crematory Swartz's
Location Balto. City

18 (a) Funeral director Wm. E. Fialkowski
(b) Address 2007 Eastern Ave, Baltimore, Md

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 May 1947, at 2:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7 May 1947, to 9 May 1947, and that I last saw h e r alive on 9 May 1947.

Immediate cause of death Cardiorespiratory failure — Duration

Due to Carcinomatosis, generalized

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause for which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter Buckner M. D.
Address Womens Hospital Date signed 9 May 47

VS 3

G51552

BALTIMORE CITY HEALTH DEPARTMENT ✓ G51552
Registered No.

CERTIFICATE OF DEATH 1210

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 618 S. Potomac St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 618 S. Potomac St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony Kuchta

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-10-1051

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1 1876

8. AGE: Years	Months	Days	If less than one day
71	4	7	hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name —
13. Birthplace Poland

MOTHER
14. Maiden Name —
15. Birthplace Poland

16 (a) Informant Anna Kuchta
(b) Address 618 S. Potomac St

17 (a) Burial (b) Date thereof 5-12-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto. Co.

18 (a) Funeral director Wm. J. Fialkowski
(b) Address 2007 Eastern Ave

MAY 1 1947
(Date rec'd by registrar)

(b) Washington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 1947, at 3:?? M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 20 1947 to May 8 1947. and that I last saw ~~him~~ her alive on May 8 1947.

	Duration
Immediate cause of death: acute pancardial + renal failure	-
Due to: Hypertensive cardiovascular disease	
Due to: Generalized arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. E. Lapp, M.D.
Address 4317 Kelvin Ave Balto Date signed 5/9/47

VS 130

X

G51553

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G51553 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. For correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1905 Edmondson Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1905 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Myers

3 (b) If veteran, name war —

3 (c) Social Security Account No. 214-16-5751

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13, 1866

8. AGE: Years 81 | Months 1 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Seamstress

11. Industry or business Ladies Clothing

FATHER 12. Name Charles N. Myers

13. Birthplace Germany

MOTHER 14. Maiden Name Cecelia A. Timmons

15. Birthplace Balto Md

16 (a) Informant Helen E. Myers

(b) Address 1905 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 12. 1947 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location City

18 (a) Funeral director Mrs. John W. Tentel & Son

(b) Address 5311 Edmondson Ave

19 (a) (b) Registrar

Registered by registrar Washington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 1947, at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to May 9. 1947, and that I last saw h[illegible] alive on May 9 1947.

Immediate cause of death Cerebral Hemorrhage — Duration 48 hours

Due to General Hardening of arteries

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Thos. H. Phillips M. D.

Address 1939 Edmondson Ave Date signed May 10-47

X

G51554

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G51554

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians—please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 6007 Sefton Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 6007 Sefton Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN P. HOERR

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-01-5282

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Minnie K. Hoerr

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6, 1883

8. AGE: Years	Months	Days	If less than one day
63	7	4	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Book Store

FATHER

12. Name Rev. John Hoerr

13. Birthplace Pa.

MOTHER

14. Maiden Name Margaret Naumann

15. Birthplace Pa.

16 (a) Informant Mrs. John P. Hoerr

(b) Address 6007 Sefton Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof May 13, 1947 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Balto., Md.

18 (a) Funeral director Lassahn Funeral Home

(b) Address 7401 Belair Road

19 (a) (Date received by registrar) 1947 (b) Registrar for William J. Mahr

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10th, 1947 at 9:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/14 1937 to 5/10 1947 and that I last saw h. alive on 5/10 1947.

Immediate cause of death	Duration
Coronary Thrombosis	1 mo.
Due to Hypertensive Cardiovascular	10 yr.
Due to Nevelopment	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Edelson

Address 6217 Belford Rd Date signed May 10 1947

X

G51555

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 99

G51555 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Light Street
(b) Street address ~~3420~~ ~~7th~~ Street
(c) Hospital or institution:
So Baltimore Gen. Hosp. V
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Brooklyn, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3420 7th Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Jane Farro

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	Married

6 (b) Name of husband or wife Louis Farro
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-31-89

8. AGE: Years	Months	Days	If less than one day
58	1	10	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name I. Herbert
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Mary Cassel
15. Birthplace Pennsylvania

16 (a) Informant Mr. Louis Farro
(b) Address 3420 7th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 12-47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location Gor Ritchie Highway
18 (a) Funeral director Milton Schilling
(b) Address 3914 Hanover St
19 (a) MAY 14 1947 (Date rec'd by registrar) (b) Signature of registrar Washington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1947 at 5.0 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1, 1947 to May 10 1947, and that I last saw her alive on May 10, 1947.

Immediate cause of death	Duration
Peripheral Vascular Collapse	72 hrs.
Due to Mesenteric Thrombosis	10 days
Due to Intraperitoneal adhesions	—
Other Conditions Carcinoma of Cervix	—

(Include pregnancy within 3 months of death)
Date of operation May 5, 1947
Major findings of operation: Mesenteric Thrombosis
of autopsy: Extension of Cancer

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rocco L. Lafaselle M. D.
Address Ls. Balto. Gen Hosp Date signed 5-10-47

VS 150

G51556

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G51556 Registered No.

61

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cost of age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Sts.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Middle River (If outside city or town limits, write RURAL and give town)
(d) Street No. Chesapeake Ave. Long Beach (If rural, give location) Middle River
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Michael Pohlhaus

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Agnes (nee Schuette)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 8, 1888

8. AGE: Years	Months	Days	If less than one day
59	4	-	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Commissioner of Labor
11. Industry or business

FATHER
12. Name Herman Pohlhaus
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Terveer
15. Birthplace Germany

16 (a) Informant Mrs. Agnes Schuette Pohlhaus
(b) Address Chesapeake Ave. Long Beach, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/12/47 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Holy Redeemer
Location Belair Road, Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

MAY 11 1947 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8th 1947, at 10.45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 7th 1947 to May 8th 1947, and that I last saw h.. alive on May 8th 1947

Immediate cause of death	Duration
Left lobar pneumonia and respiratory failure	
Due to Myocardial insufficiency	1 day
Due to	
Other Conditions Diabetes mellitus	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. E. Gonzalez M.D.
Address Maryland G. Hospital Date signed 5/8/47

Huntington Williams, MD

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G51557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G51557 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1605 N. Milton Avenue
(c) Hospital or institution: q

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1605 N. Milton Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BARBARA ZUNT

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife John Zunt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8, 1879

8. AGE: Years	Months	Days	If less than one day
68 yrs.		2	hr. min.

9. Birthplace Czechoslovakia
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant John Zunt - husband
(b) Address 1605 N. Milton Avenue

17 (a) Burial (b) Date thereof 5/13/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Horner's Lane, Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) 1947 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 May 1947, at 9.45A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11 May 1946 to 10 May 1947, and that I last saw h[illegible] alive on 2 May 1947.

Immediate cause of death Myocardial failure — Duration 2 months

Due to Arteriosclerosis

Due to [illegible]

Other Conditions Diabetes

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard Eastman

Address 1513 N. Milton Ave Date signed 10 May 47

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G51558 | BALTIMORE CITY HEALTH DEPARTMENT | G51558 Registered No.

CERTIFICATE OF DEATH 94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1336 Northern Pk.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give name)
(d) Street No. 1336 Northern Pk. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Norman B. Hagan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Antoinette

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 12-1888

8. AGE: Years 58 | Months 5 | Days 28 | If less than one day hr. min.

9. Birthplace Frederick Md. (Town, county, and state)

10. Usual Occupation Engineer

11. Industry or business Bendix Corp.

FATHER 12. Name Richard Hagan

13. Birthplace Frederick, Md.

MOTHER 14. Maiden Name Mary Kaiser

15. Birthplace Hagerstown Md.

16 (a) Informant Antoinette Hagan

(b) Address 1336 Northern Pk

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/12/47 (Month) (day) (year)

(c) Cemetery or crematory Mt. Olivet

Location Frederick Md.

18 (a) Funeral director John J. Hoban

(b) Address 4801 Belmont Av

19 (a) (Date received by Registrar) (b) Registrar

MAY 11 1947

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1947 to May 9 1947 and that I last saw h[illegible] alive on May 9 1947

Immediate cause of death: Cardiac Coronary Occlusion — Duration: 1 day

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jacob Dewyer M.D.

Address 4808 Harford Date signed 5-10-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51559

BALTIMORE CITY HEALTH DEPARTMENT ✓ G51559 Registered No.

CERTIFICATE OF DEATH 1278

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2823 Riggs ave (If rural, give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Helen J. Thiel

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife John A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 13th 1889

8. AGE: Years 58 | Months 7 | Days 25 | If less than one day ... hr. ... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation H.W.

11. Industry or business

FATHER 12. Name Charles Zydenis
13. Birthplace Md.

MOTHER 14. Maiden Name Mary Hanson
15. Birthplace Md.

16 (a) Informant Husband.
(b) Address Above

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/12/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto Md.

18 (a) Funeral director Ed. Fanning & Son
(b) Address 1938 E. Lafayette Ave.

19 (a) ... (Date received by registrar) (b) ... Registrar

MAY 11 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-8 1947, at 9:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-4 1947 to 5-8 1947 and that I last saw her alive on 5-4 1947

Immediate cause of death Pulmonary Embolism
site unknown

Due to ...

Due to ...

Other Conditions ...
(Include pregnancy within 3 months of death)

Date of operation 5-6-47

Major findings of operation: Lipoma
Sail Bladder

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ...
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. Woodeman

Address ... Date signed 5-9 (M. D.)

G51560

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G51560 Registered No.

write the causes of death clearly and legibly. Physicians: please write correct age is especially important. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 612 W. Fayette Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas E. Wimmer

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1903

8. AGE: Years	Months	Days	If less than one day
44			hr. min.

9. Birthplace Gatewood, West Va. (Town, county, and state)

10. Usual Occupation Sample

11. Industry or business Self

FATHER
12. Name John Wimmer
13. Birthplace Va

MOTHER
14. Maiden Name Sarah Baer
15. Birthplace N Carolina.

16 (a) Informant Mrs Sarah Moore.
(b) Address Fayetteville, West Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/13/47 (month) (day) (year)
(c) Cemetery or crematory Oak Hill Cem
Location Oak Hill West Va

18 (a) Funeral director John Conway Son
(b) Address 90 & 92 Baltimore St

19 MAY 12 1947 (b) Washington Metropolitan, M.D. Registrar

MAY 12 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10, 1947, at 6:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Congestive Heart Failure -

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L. Reyer M.D. Medical Examiner

Date signed 5/10/47

X

G51561

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a

Register No. G51561

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1501 Rutland Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1501 Rutland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna M. Elgert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife J. William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21 1891

8. AGE: Years	Months	Days	If less than one day
56	0	17	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Charles J. Itzel
13. Birthplace Baltimore

MOTHER
14. Maiden Name Sophia Freking
15. Birthplace Baltimore

16 (a) Informant Husband
(b) Address 1501 Rutland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/12/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave. & Rose St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

19 MAY 12 1947 Attesting for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 1947, at 9:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1946 to May 1947
and that I last saw her alive on May 4 1947

Immediate cause of death: Ca of cervix
Bronchopneumonia

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Conrad L. Richter M. D.
Address 1101 N Ward St Date signed 5/12/47

VS 150

Richter x

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

051562

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

051562 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden + Madison Sts
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5819 Halwyn Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Priebe

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-01-476

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	M

6 (b) Name of ~~husband or~~ wife Emma M. Priebe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 8 1882

8. AGE: Years	Months	Days	If less than one day
64	5	2	hr. min.

9. Birthplace Balto. Co. Md.
(Town, county, and state)
10. Usual Occupation Machine Operator
11. Industry or business Black & Decker

FATHER
12. Name Erdman Priebe
13. Birthplace Germany

MOTHER
14. Maiden Name Alvina Schwartz
15. Birthplace Germany

16 (a) Informant Emma Priebe
(b) Address 5819 Halwyn Ave

17 (a) Burial (b) Date thereof 5/14/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Meadow Ridge
Location Montgomery Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) MAY 12 1947 (b) Huntington for Williams, M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10th 1947, at 8:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 10th 1947, to May 10th 1947, and that I last saw h~~im~~er alive on May 10th 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Bronchopneumonia and chronic bronchial asthma	1 day
Due to Myocardial failure	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. E. Gonzalez
Address Maryland Gen. Hospital Date signed 5/10/47 M.D.

VS 150

51563

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

G51563 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1006 St. George's Road
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1006 St. George's Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Roland Stevens

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Julia Agnes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 23, 1879

8. AGE: Years	Months	Days	If less than one day
68	3	18	hr. min.

9. Birthplace Richmond, Virginia
(Town, county, and state)
10. Usual Occupation Caretaker
11. Industry or business

FATHER
12. Name Wm. H. Stevens
13. Birthplace Richmond, Va.

MOTHER
14. Maiden Name Pauline Tate
15. Birthplace Richmond, Va.

16 (a) Informant Miss Va. M. Stevens
(b) Address 1006 St. George's Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 13-47 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Baltimore Co. Md.

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) (Date received by local registrar) (b) Waiting for Will

MAY 12 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10, 1947, at 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1946, to May 1947, and that I last saw him alive on May 10 1947.

Immediate cause of death: Carcinoma of lung — Duration 3 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William B. Herman M. D.
Address 1041 St. Paul St. Date signed 5-10-47

X

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. Type or write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G51564

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1170

G51564 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1922 Lord St., Balto.
(c) Hospital or institution: Maryland Gen'l Hosp. 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1922 Lord St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas M. Dailey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 21st 1898

8. AGE: Years	Months	Days	If less than one day
48	8	19	hr. min.

9. Birthplace Baltimore Md (City, county, and state)

10. Usual Occupation Laborer Watchman

11. Industry or business City of Balto.

FATHER
12. Name Wm. J. Dailey
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen Duffy
15. Birthplace Ireland

16 (a) Informant Rose A. Dailey
(b) Address 1920 Lord St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/13/47 (month) (day) (year)
(c) Cemetery ~~co-cemetery~~ St. Peters
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 217 St. Paul St.

19 MAY 12 1947 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1947, at 5-14 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-26 1947 to 5-10 1947, and that I last saw h.im alive on 5-10 1947

Immediate cause of death	Duration
Pulmonary Infection	2 Days
Due to Post Operative Hemorrhage	10 Days
Due to Peptic Ulcer.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 5-1-47

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. A. Cummins M. D.
Address Md. Gen Hosp. Date signed

VS 150

G51565

BALTIMORE CITY HEALTH DEPARTMENT X V

CERTIFICATE OF DEATH

105

Registered No. G51565

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 0 0 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Towson (Towson Estates) (If outside city or town limits, write RURAL and give town)
(d) Street No. 110 Edgewood Road (If rural, give location)
(e) Citizen of foreign country? — No — (Yes or No)
If yes, name country —

3 (a) FULL NAME William Epperson Gilmore Jr.

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: None

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 25 1941

8. AGE: Years 6 | Months 1 | Days 17 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation School Boy

11. Industry or business School

FATHER — 12. Name Dr. Wm. E. Gilmore

13. Birthplace Pennsylvania

MOTHER — 14. Maiden Name Majorie E. Young

15. Birthplace Massachusetts

16 (a) Informant Dr. W. E. Gilmore - Father

(b) Address 110 Edgewood - Towson

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 13 47 (month) (day) (year)

(c) Cemetery or crematory Oak Grove

Location Uniontown - Penna

18 (a) Funeral director Stuart Morris Co.

(b) Address 409 W York Ave.

19 (a) MAY 12 1947 (Date rec'd by registrar) Huntington Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1947, at 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 11 1947 to May 11 1947 and that I last saw h. alive on May 11 1947

Immediate cause of death	Duration
Laryngeal edema - obstruction	
Due to Infection	
Due to —	two
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Crawford N. Kellerbrand, Jr. M. D.

Address Union Mem. Hosp. Date signed 5-11-47

VS 150

X

G51566

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G51566

CM 21482

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 11 23
(e) Length of stay in Baltimore (yrs., mos., or days) 20 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 426 W. Biddle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alonzo Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Lottie (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 27- 1887 ?

8. AGE: Years 60 | Months 0 | Days 9 | If less than one day ... hr. ... min.

9. Birthplace Washington D.C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Johnson
13. Birthplace Washington D.C.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 12, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary cemetery
Location cedar hill Maryland

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Avenue

19 (a) MAY 12 1947 (Date received by Registrar) (b) Huntington Williams M.D. (Signature of Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 19 47, at 1.35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-13-43 19 43 to May 6 19 47, and that I last saw him alive on 5-6- 19 47.

	Duration
Immediate cause of death: Cardiac Failure	
Due to: Hypertensive CVD.	
Due to:	
Other Condition: Old. CVA - Lt hemiplegia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no Post -

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Beadleson M. D.

Address Baltimore City Hosp Date signed 6 May 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51567

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G51567

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1127 E Lexington St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or Town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1127 E Lexington Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country no

3 (a) FULL NAME ALFRED MARINA

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	married

6 (b) Name of husband or wife Nelia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years	Months	Days	If less than one day
50	SMT.		hr. min.

9. Birthplace Anderson, South Carolina
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Md. Car Wheel Co.

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Nannie Harris
(b) Address 1127 E. Lexington Street

17 (a) Burial (b) Date thereof May 14 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director A. Halstead Dennis Hall
(b) Address

19 (a) MAY 12 1947 Harrington-Williams, Inc.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/8/47 19 5:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John Peters M.D.
Medical Examiner.
Date signed 5/8/47

VS 191

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51568

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G51568 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 954 Forrest St.

(c) Hospital or institution Maryland Penitentiary Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 Yr 3 10

(e) Length of stay in Baltimore (yrs., mos., or days) ✓

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 954 - Forrest St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Howard B Young

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 72 Months ? Days ? If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Farmhand

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace Unknown

MOTHER 14. Maiden Name Unknown

15. Birthplace Unknown

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School MAY 7 1947

18 (a) Funeral director Commissioner of Health

(b) Address

19 MAY 12 1947 (Date rec'd by registrar)

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1947, at 1:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 19, 1947, to April 20 1947 and that I last saw h[illegible] alive on April 20 1947

Immediate cause of death: Cerebral Hemorrhage — Duration 24 hr.

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Lewis G. Garrett. M. D.

Address Maryland Penitentiary Date signed 4-20-47

X

G51569

CMK-109611

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH · 13B

Registered No. G51569

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 17 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1407 Barnes Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Roberta Coleman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife Esa Coleman (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16-1915

8. AGE: Years	Months	Days	If less than one day
31	11	6	hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Elbert Johnson
13. Birthplace North Carolina

MOTHER
14. Maiden Name Lenora Dempsey
15. Birthplace North Carolina

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School MAY 7 1947

18 (a) Funeral director Commissioner of Health
(b) Address

(a) (Date rec'd by registrar) MAY 12 1947 Registrar for Williams, M.D.

MEDICAL CERTIFICATION

P

20. DATE OF DEATH April 22 19 47, at 7:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 2 19 47, to April 22 19 47, and that I last saw her alive on April 22 19 47.

	Duration
Immediate cause of death Pulmonary Tuberculosis, Far-Advanced	4 mo.?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Not Obtained

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Hunt M. D.
Address Balt City Hospitals Date signed 4-25-47

VS 150

CERTIFY THAT ALL INFORMATION IS CORRECT, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51570

BALTIMORE CITY HEALTH DEPARTMENT

BC# B77962 CERTIFICATE OF DEATH 159

G51570
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1502 Plum St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Souza
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 5-6-47
8. AGE: Years | Months | Days | If less than one day: 8 hr. 30 min.
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Souza
13. Birthplace Mass

MOTHER
14. Maiden Name Edith Cooley
15. Birthplace Conn.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo MAY 7 1947

18 (a) Funeral director Commissioner of Health
(b) Address
MAY 12 1947 (Date rec'd by registrar) (by) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May - 7 - 1947, at 6 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 6 1947 to May 7 1947 and that I last saw h alive on May 7 1947

Immediate cause of death	Duration
PREMATURITY	
Wt. 5 lbs 15 ozs.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D H Riggins M. D.
Address Johns Hopkins Hosp Date signed 5-7-47

VS 150

X

G51571 BCH 77667

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G51571 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital, Balto. 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 St. Matthews
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Allen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/30/47

8. AGE: Years	Months	Days	If less than one day
—	—	3	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation infant.

11. Industry or business

FATHER
12. Name Paul Allen
13. Birthplace

MOTHER
14. Maiden Name Clara Pittman
15. Birthplace

16 (a) Informant Clara Allen
(b) Address (Balto.) 1208 St. Matthews

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School MAY 9 1947

18 (a) Funeral director Commissioner of Health
(b) Address

MAY 12 1947 Date received by Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3, 1947, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1947, to May 3 1947, and that I last saw h alive on May 3 1947

Immediate cause of death Bronchopneumonia

Due to Prematurity.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos. F. Hann Jr. M.D.
M. D.
Address Un. Hosp., Balto., Md. Date signed 5/13/47

G51572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1313

G51572 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 583 Chapel St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Glasgow

3 (a) FULL NAME Lovest Powell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race N | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years 27 ? | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace ?
(Town, county, and state)

10. Usual Occupation

11. Industry or business Laborer

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

(Date rec'd by registrar) (b)

University Medical School MAY 9 1947
Commissioner of Health
MAY 12 1947

VE 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/18 1947, at 7:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/15 1947 to 4/18 1947, and that I last saw h[illegible] alive on 4/18 1947.

Immediate cause of death (a) Bs. Meningitis
Pulmonary Tuberculosis

Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. W. Maples M.D.
Address Providence Hospital Date signed 4/19/47

G51573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

Registered No. G51573

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 31st & St. Paul Sts.
(c) Hospital or institution: Hopkins Apts. No. 814
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 31st & St. Paul Sts.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN WILLIAM SMITH

3 (b) If veteran, name war: No
3 (c) Social Security Account No. No

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Blanche Smith
nee Kingsmore
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6, 1866

8. AGE: Years 81 | Months 2 | Days 4 | If less than one day hr. min.

9. Birthplace London, England
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Wm. T. Smith
13. Birthplace England

MOTHER
14. Maiden Name Margaret --
15. Birthplace Unknown

16 (a) Informant Mr. Wm. T. Smith, son
(b) Address Media, Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/12/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAY 12 1947 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10, 1947, at 9:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1st 1947, to May 10th 1947, and that I last saw h[illegible] alive on May 9th 1947.

	Duration
Immediate cause of death: Myocardial Insufficiency / Pulmonary Edema	4 days / 2 days
Due to: Arterio Sclerosis	10 yrs
Due to:	
Other Conditions: Prostatic Hypertrophy	5 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. A. Schaefer M. D.
Address 1300 N. Calvert St. Date signed May 12 1947

Rec'd Reg'd MAY 12 1947

VS 150

93E

...every item of information should be carefully supplied. ...PRINTING, WITH UNFADING INK. ...correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51574

BALTIMORE CITY HEALTH DEPARTMENT

BCHD 33614 CERTIFICATE OF DEATH 186a

Registered No. G51574

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A. A.
(c) City or town Hanover (If outside city or town limits, write RURAL and give town)
(d) Street No. Ridge Road (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME John Theodore Day

3 (b) If veteran, name war.....

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age 9-28-45 years

7. Birth date of deceased (mo., day, yr.) Oct. 2, 1945

8. AGE: Years	Months	Days	If less than one day
1	7	11	.....hr. .....min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER
12. Name Alan Day
13. Birthplace Easton, Md.

MOTHER
14. Maiden Name Lillian A. Prenger
15. Birthplace Balto., Md.

16 (a) Informant Miss Doris M. Prenger
(b) Address 215 W. 29th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/12/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAY 12 1947 (Date rec'd by registrar) (b) Huntington Nolliaux, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9, 1947 at 8 06 P. M.

21. I certify that I took charge of the remains described above, held an Inspection + Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Cervical Vertebra

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5/7/47 at P. M.
(b) Where did injury occur? Ridge Rd., Hanover Md
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fell from crib

23. Signature Howard F. Mellenis M.D.
Medical Examiner.
Date signed 5/9/47

G51575

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G51575 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hosp. 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 545 Biddle St. (If rural give location)
(e) Citizen of foreign country? Bloom (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES HOLLAND

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: N
6 (a) Single, married, widowed, or divorced: W. Dowd

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/27/1873

8. AGE: Years 73 | Months 6 5 | Days 12 | If less than one day hr. min.

9. Birthplace Frederick, Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Henson Holland
13. Birthplace Frederick Co. Md.

MOTHER
14. Maiden Name Mary Garner
15. Birthplace Frederick Co. Md.

16 (a) Informant Mrs. Sarah Jones
(b) Address 545 Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 12 1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Park.
Location Baltimore Co. Md.

18 (a) Funeral dir. Chas. H. Holland
(b) Address 1617 Druid Hill Ave.

19 (a) MAY 12 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/8 1947 at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/5 1947 to 5/8 1947. and that I last saw him alive on 5/8 1947.

Immediate cause of death Cerebral Accident — Duration

Due to Hypertension, Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. K. Adams M. D.
Address 1222 N. Carey Date signed 5-9-47

VS 150

G51576

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

Registered No. G51576

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be made on typewriter or print and write the causes of death clearly and legibly. Underline the cause for which death should be charged statistically. Give full name of deceased, and if a married woman, the name of her husband. Do not use initials but write out full name. Give correct age in years, months, days, hours, or minutes. Physicians: please write the causes of death clearly and legibly. Underline the cause for which death should be charged statistically. Entries must be made on typewriter or print and write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 703 N. Mount St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 703 N. Mount St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louisa Conrad

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Rufus
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec. 11, 1867
8. AGE: Years 79 | Months 4 | Days 21 | If less than one day hr. min.
9. Birthplace Lexington, Kentucky (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Aaron Bond
13. Birthplace Kentucky

MOTHER
14. Maiden Name Georgia ?!
15. Birthplace Kentucky

16 (a) Informant Mrs. Louisa Stewart
(b) Address 1221 Argyle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 13, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave

19 (a) MAY 12 1947 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8, 1947, at 10:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/1/1947 to 5/8/1947, and that I last saw h[illegible] alive on 5/7/1947.

Immediate cause of death	Duration
Chronic Cardio-Vascular Renal Disease	1 Year
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. C. Jackson M.D.
Address 6001 Allentown sign 5/9/47

VS 150

G51577

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G51577

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3042 Edmondson Ave
(c) Hospital or institution 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3042 Edmondson Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Blanche Geiser

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11 1876

8. AGE: Years	Months	Days	If less than one day
71	9	24	hr. min.

9. Birthplace Maryland Carroll Co
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Housewife

FATHER
12. Name James Mavis
13. Birthplace Carroll Co Md

MOTHER
14. Maiden Name Katherine Elliot
15. Birthplace Caroline Co Md

16 (a) Informant Miss Blanche Geiser
(b) Address 3042 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/12/47 (month) (day) (year)

(c) Cemetery or crematory Lorraine Park Cem
Location

18 (a) Funeral director Chas P Powell
(b) Address 2427 Edmondson Ave

19 (a) (Date received by local registrar) MAY 12 1947 (b) Huntington Williamsport, Md

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/10 1947, at 1000 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1947, to May 10 1947, and that I last saw h[illegible] alive on May 10 1947

Immediate cause of death: Myocardial degeneration

Due to: arteriosclerosis

Due to:

Other Conditions: Hypertension
(Include pregnancy within 3 months of death)

Major findings:
Of operations:

Of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward Novak M. D.
Address 1011 W. Read St Date signed 5-12-47

X

Dora M.L. Muhly

G51578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 83a

Registered No. G51578

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4311 Maine Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4311 Maine Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Dora M L Muhly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female 5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Geo. H. Muhly (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 20 1869

8. AGE: Years 78 | Months 2 | Days 17 | If less than one day hr. min.

9. Birthplace Balto md (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name Herman C Frentz

13. Birthplace Germany

MOTHER 14. Maiden Name Louisa Pfeffelsdorf

15. Birthplace Germany

16 (a) Informant Melvin J Muhly

(b) Address 4335 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 12 1947 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Balto Co

18 (a) Funeral director A Reiley Slade

(b) Address 4907 York Road

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MAY 12 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 1947, at 10:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/25 1946, to May 9, 1947, and that I last saw h[illegible] alive on May 9, 1947.

	Duration
Immediate cause of death: Cerebral apoplexy	7 hours
Due to: Arterio-sclerosis with hypertension	6 yrs.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Maurice L. Shamer M. D.

Address 3300 N. Charles St Date signed 5/10/47

X

G51579

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

DC# B-47215 160a

Registered No. G51579

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1959 N. Patterson Park (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Elmer Hess

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-15-46.

8. AGE: Years 1 Months 11 Days 26 If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Leonard Hess
13. Birthplace Md

MOTHER
14. Maiden Name Myrtle Wayter
15. Birthplace Mass

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address Research.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/13/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore County
Location North Ave & Rose Hill
Forward H. Bright Jr.

18 (a) Funeral director
(b) Address 4914 Belair Road

19 MAY 12 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1947 at 7:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 7 1947 to May 11 1947, and that I last saw him alive on May 11 1947

Immediate cause of death: Respiratory failure — Duration: 2 hr

Due to: Meningitis — 14 days

Due to: Hemophilus influenza B

Other Conditions: Sub dural hematoma

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Elliott J. Sheldon, M.D.

Address Date signed 5/13/47

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51580

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G51580

CM. 15839

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 D- 21
(e) Length of stay in Baltimore (yrs., mos., or days) 64 Yrs,

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Orchard Ave. Brooklyn MD. (If rural give location)
(e) Citizen of foreign country? England Yes (Yes or No)
If yes, name country England

3 (a) FULL NAME Jenks, Edwin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Fannie(D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb.20 -1865

8. AGE: Years	Months	Days	If less than one day
82	2	19	hr. min.

9. Birthplace England (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Richard Jenks (D)
13. Birthplace England

MOTHER
14. Maiden Name Emily Howell(D)
15. Birthplace England

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/12/1947 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A.A. Co. Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light Street

19 (Date rec'd by registrar) MAY 12 1947 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 1947, at 10.30AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 18- 1929 to May 9 -1947, and that I last saw h. im alive on May 9 - 1947

Immediate cause of death	Duration
Coronary occlusion -	
Due to Arteriosclerotic cardio-vascular disease.	
Due to	
Other Conditions Cachexia	

(Include pregnancy within 3 months of death)

Date of operation 4/17/47
Major findings of operation: Osteomyelitis, tibia, left foot.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. A. Gibbs
Address Balto. City Hospitals Date signed 5/9/47

VS 150

correct are is especially important. Physicians: please write the causes of death clearly and legibly.

G51581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G51581

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1140 Dexter Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HARRY SAMUEL SULLIVAN

3 (b) If veteran, name war None

3 (c) Social Security Account No. 216-09-7254

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) ? 1885

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Glass Blower

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Margaret D. Judt
(b) Address 1513 McHenry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 14-1947 (month, day, year)
(c) Cemetery or crematory Mt Olivet
Location Balto Md

18 (a) Funeral director Pratt & Stricker St
(b) Address

19 (a) MAY 12 1947 (Date rec'd by registrar) (b) Huntington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9, 1947, at 2 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D. Medical Examiner.
Date signed 5-10-47

VS 151

Conform to spelling as carefully important. Physicians: please write the causes of death clearly and legibly.

C51582

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1310

Registered No. C51582

Please write the causes of death clearly and legibly. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A.
(b) Street address 801 N. Calvert St
(c) Hospital or institution: ----------
(d) Length of stay in hospital or inst. (yrs., mos., or days) -----
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 801 N Calvert St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine H. Chambers

3 (b) If veteran, name war ----------
3 (c) Social Security Account No. ----------

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband ##### Robert S. Chambers
6 (c) If alive, give age ---years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
98			____hr. ____min.

9. Birthplace Frederick, Md. (Town, county, and state)
10. Usual Occupation At home
11. Industry or business ----------

FATHER
12. Name Peter William Haydock
13. Birthplace Austria

MOTHER
14. Maiden Name Christine Miller
15. Birthplace Germany

16 (a) Informant Miss Annette A. Haydock
(b) Address 801 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/13/47 (month) (day) (year)
(c) Cemetery ######## New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. H. Mears and Son
(b) Address 805 N. Calvert St.

19 MAY 12 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/10 1947 at 8:25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiac Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature D. J. Salamotis M.D.
Medical Examiner.
Date signed 5/10/47

VS 181

X

51583

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G51583

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General 11

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 421 Linden Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALBERT WALLACE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife Lethia Wallace

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) 1882 Dec 24

8. AGE: Years	Months	Days	If less than one day
64 65	5	16 18	hr. min.

9. Birthplace Montgomery Co Md
(Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER
12. Name Lucas Wallace
13. Birthplace Md

MOTHER
14. Maiden Name Amanda King
15. Birthplace Md

16 (a) Informant Lethia Wallace
(b) Address Brookeville Md

17 (a) Burial (b) Date thereof May 13-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Zion
Location Montgomery Co Md

18 (a) Funeral director Roy W Barber
(b) Address Brookeville Md

MAY 12 1947 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/11/47 19..., at 1:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Hes death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D.
Medical Examiner.
Date signed 5/12/47

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51584

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G51584

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1224 E.Federal Street
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1224 E.Federal Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Carroll Thomas Beach Sr.

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary E.Eagan
6 (c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.) Oct 2 1885

8. AGE: Years: 61 | Months: 7 | Days: 8 | If less than one day: ########## hr. min.

9. Birthplace Baltimore,Md. (Town, county, and state)
10. Usual Occupation Retired Mail carrier
11. Industry or business U.S.Mail

FATHER
12. Name Thomas Beach
13. Birthplace Baltimore,Md.

MOTHER
14. Maiden Name Adelaide I.York
15. Birthplace Baltimore,Md.

16 (a) Informant Mrs.Mary E.Beach (Wife)
(b) Address 1224 E.Federal Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/13/47 (month) (day) (year)
(c) Cemetery or crematory Merlands Memorial Park
Location Taylor Avenue Balto:Co.

18 (a) Funeral director George J.Ruth,Inc.
(b) Address 1735 Harford Avenue

19 MAY 12 1947 (b) Thurlings for Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10th., 1947, at 1:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1946 to May 10 1947.
and that I last saw him alive on May 9 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	72 hrs.
Due to	
Due to	
Other Conditions Cerebral paralysis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Bremer
Address 1402 E.Lanvale Date signed 5-10-47

V S 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51585

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 94a

G51585 Registered No.

Every item of information should be carefully supplied. The age is especially important. Physicians please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 706 Greenmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 706 Greenmount Ave (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME George or Gaetano Napoleone

3 (b) If veteran, name war none

3 (c) Social Security Account No. 213--03-8944

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	White	Widowed

6 (b) Name of ~~husband~~ or wife late Amalia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6 1880

8. AGE: Years	Months	Days	If less than one day
67		4	hr. min.

9. Birthplace Atolata Italy
(Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business S.M. Tailoring Co.

FATHER
12. Name Angelo Napoleone
13. Birthplace Italy

MOTHER
14. Maiden Name Elisabetta Mannella
15. Birthplace Italy

16 (a) Informant Elenora Donatelli (Niece)
(b) Address 706 Greenmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 13 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer.
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rose
(b) Address 52 N. Morley St.

5 12 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/10th 1947 at 6 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/12th 1947 to 5/19th 1947 and that I last saw h~~e~~r alive on 5/9th 1947.

Immediate cause of death Coronary occlusion — Duration 2 hrs

Due to arterio sclerosis — 2

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hyl. Jenkins M.D.

Address 10 N. Eutaw Date signed 5/16/47

G51586

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

G51586 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland St.
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 308 N. Pulaski St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa Lamartina

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband XXXX late Cosimo

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 2 1882

8. AGE: Years 64 | Months 9 | Days 9 | If less than one day hr. min.

9. Birthplace Cefalu Palermo Italy
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER
12. Name Iachino Serio
13. Birthplace Italy

MOTHER
14. Maiden Name Concetta Martino
15. Birthplace Italy

16 (a) Informant Mary Ruvolazzo
(b) Address 28 Wheler Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 14 1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Frank Dellaluce
(b) Address 82e N. Morley St.

19 (a) Filed by registrar Huntington Williams, M.D. 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/11/47 1947, at 3 Co A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/9 1947 to 5/11 1947, and that I last saw h[illegible] alive on 5/10 1947

Immediate cause of death - Coronary Occl.
Arteriosclerosis Cardiaca
Conditions

Due to [illegible] Coronary Embolism

Due to Acute Fibrillation + ACVD

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leon Rosenbaum M.D.
Address Sinai Hospital Date signed 5/11/47

V S 150

X

G51587

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G51587
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2123 Druid Hill Ave.
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2123 Druid Hill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Covington

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex Female

5. Color or race Col.

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife –

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Simon Johnson
13. Birthplace Essex Co., Va.

MOTHER
14. Maiden Name Martha Johnson
15. Birthplace Essex Co., Va.

16 (a) Informant Betrice Creigler
(b) Address 2125 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/12/47 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantly Ave.

19 (a) 12 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-8- 19 47 at 7:34 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-6 19 25, to 5-8- 19 47
and that I last saw h[illegible] alive on 5-8-47 19

Immediate cause of death: Cardiac & Respiratory Failure — Duration

Due to: Cerebral Hemorrhage - Infarct — 2 yrs

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Luke E. Adams M. D.
Address 7340 Marshall Date signed 4-12-47

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BCH

BALTIMORE CITY HEALTH DEPARTMENT

G51588

Registered No. G51588 B66340

CERTIFICATE OF DEATH 15-7a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 605 Chapel Gate Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 605 Chapel Gate Lane N. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William George Ruby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-28-46

8. AGE: Years | Months 4 | Days 13 14 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Rosa D. Ruby
13. Birthplace Maryland

MOTHER 14. Maiden Name Elsie N. Unverzagt
15. Birthplace Maryland

16 (a) Informant Elsie N. Unverzagt
(b) Address 605 Chapel Gate Land

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-12-47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore - Md.

18 (a) Funeral director Edw. L. McNabb
(b) Address Catonsville 28 - Md.

19 (a) (Signature of registrar) (b) Washington Hollow, Md.

MAY 12 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1947, at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to May 11 1947 and that I last saw him alive on May 11 1947.

Immediate cause of death Pulmonary Edema — Duration

Due to

Due to Hydrocephalus - Fetal Spina Bifida - Myocarditis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry W. Wolfe M.D.
Address Reisterstown, Md. Date signed 5-12-47

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51589

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G51589

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.O.A.
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4225 Euclid Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Walter Hengler

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-05-0112

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Karalyn A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24, 1889

8. AGE: Years 57 | Months 9 | Days 16 | If less than one day hr. min.

9. Birthplace Balto., Md
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business J. R. Smith & Co

FATHER
12. Name Geo. Henry Hengler
13. Birthplace Md.

MOTHER
14. Maiden Name Ernestine Gleim
15. Birthplace Md.

16 (a) Informant Mrs. Geo. Walter Hengler
(b) Address 4225 Euclid ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 | 14 | 47. (month) (day) (year)

(c) Cemetery or crematory Westerns
Location Edmondson Ave & Longwood St.

18 (a) Funeral director Harry H. Kittle
(b) Address 4101 Edmondson ave

19 (d) MAY 12 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/10 1947, at 3:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. F. Leibrecht M.D. Medical Examiner.
Date signed 5/10/47

VS 191

G51590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 107

G51590 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2406 Puget St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2406 Puget St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Patterson

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-05-3420

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Widowed

6 (b) Name of husband or wife MARY (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 29, 1877

8. AGE: Years	Months	Days	If less than one day
69 67	8	11	hr. min.

9. Birthplace VA.
(Town, county, and state)
10. Usual Occupation LABORER – Retired
11. Industry or business

FATHER
12. Name WM. H. PATTERSON
13. Birthplace VA.

MOTHER
14. Maiden Name MARTHA BELLMAN
15. Birthplace VA.

16 (a) Informant HOWARD PATTERSON
(b) Address 1218 MADISON AVE

17 (a) BURIAL (b) Date thereof 5/13/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory MT. ZION
Location BALTO. MD

18 (a) Funeral director Joseph B. Locke, Jr.
(b) Address 1324 N. Central Ave

19 MAY 12 1947 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/9 1947, at 7:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/7 1947 to 5-9- 1947 and that I last saw him alive on 5/9 1947

Immediate cause of death: Acute Endo-Carditis & Pericarditis — 30 days
Due to: Pneumonia with Pleurisy — 60 days
Other Conditions: Coronary Sclerosis (Acute) — 60 days
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jas. R. Black M.D.
Address 1327 N. Central Ave Attended from 5/7 to 5/9

5/12/47

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C51591

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

Registered No. C51591

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Stewart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Clayton Stewart

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1854

8. AGE: Years	Months	Days	If less than one day
92	5	14	hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Seamstress (Retired)

11. Industry or business

FATHER 12. Name: Michael Fleming

13. Birthplace: Ireland

MOTHER 14. Maiden Name: Elizabeth McCrory

15. Birthplace: England

16 (a) Informant: Little Sisters of the Poor

(b) Address: 1200 Valley St - City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-13-47 (month) (day) (year)

(c) Cemetery or crematory: New Cathedral

Location: Old Frederick Rd.

18 (a) Funeral director: Edward St. Cooke & Son

(b) Address: 924 E. Eager St.

19 (a) (Date received by registrar) (b) Huntington Williams, M.D.

MAY 12 1947 VS 50

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1947, at 2:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 - 1947, to May 10 1947, and that I last saw her alive on May 10 - 1947

Immediate cause of death: Edema Lungs — Duration: 1 day

Due to: Mitral Stenosis — 5 yrs

Due to:

Other Conditions: Arterio Sclerosis - — 10 yrs

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E Gill Hall M. D.

Address 1631 E. North Av Date signed May 11-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51592

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

63c

Registered G51592

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Ellicott City
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa Miller

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife Wm Miller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 26, 1890

8. AGE: Years 56 | Months 8 | Days 14 17 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name John Addeson
13. Birthplace Md

MOTHER
14. Maiden Name Eliz. Wesley
15. Birthplace Md

16 (a) Informant Joseph Miller
(b) Address Ellicott City Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-13-47 (month) (day) (year)
(c) Cemetery or crematory Good Shepherd
Location Ellicott City, Md.

18 (a) Funeral director J. C. Higinbotham
(b) Address Ellicott City Md.

19 (a) MAY 12 1947 (Date received by registrar)

Signature [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-9 1947 at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-23 1947, to 5-9 1947, and that I last saw h[illegible] alive on 5-9 1947

Immediate cause of death: Pneumonia, lobar

Due to: Hypostatic pneumonia

Due to: Coronary art.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]

Address [illegible] Date signed 5-9-47 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Please write the causes of death clearly and legibly.

(51593)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. (51593)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp. 7
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1009 N. Chapel Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William C. STOKES

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-01-8953

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years	Months	Days	If less than one day
45			hr. min.

9. Birthplace Glenaster Co., Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Thomas Stokes
13. Birthplace Virginia

MOTHER
14. Maiden Name Fannie Stokes
15. Birthplace Virginia

16 (a) Informant Mrs. Edith Stokes
(b) Address 1009 N. Chapel St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-14-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore Maryland

18 (a) Funeral director Charles P. Lee
(b) Address 202 Madison Ave.

19 MAY 12 1947 (Date rec'd by registrar) Huntington Williams, MD Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9, 1947, at 10 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Lobar pneumonia, rt. lung.
Myocardial degeneration
Due to Nephrosclerosis

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Geo. G. Merrill M.D. Medical Examiner.
Date signed 5/10/47

C51594

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Register C51594

C.M. 109812

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 Days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1133 Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dickerson, Mary

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: James Dickerson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May - ?- ? 1859

8. AGE: Years 48 | Months ? | Days ? | If less than one day ... hr. ... min.

9. Birthplace MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas Brown (D)
13. Birthplace MD.

MOTHER
14. Maiden Name Ella Weems (D)
15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 12, 1947 (month) (day) (year)
(c) Cemetery or crematory Dropps
Location Dropps, Md.

18 (a) Funeral director P. Ellis Clark
(b) Address Easton, Md.

19 MAY 12 1947 Thurston Williams M.D. Registrar

MEDICAL CERTIFICATION

AM

20. DATE OF DEATH May 9, 1947, at 11.00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April -11 1947 to May -9 - 1947, and that I last saw her alive on May -9 1947.

Immediate cause of death C-V Accident

Due to Hypertension C-V Disease - Malignant

Due to

Other Conditions Nephrosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

	Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert R. Fowler M. D.
Address Balto. City Hosp. Date signed 5-9-47

VS 150

937

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

AdCo. 5-31 2500

G51595 **HEALTH DEPARTMENT—CITY OF BALTIMORE** G51595

CERTIFICATE OF DEATH ✓ 9213

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1031 Argyle Ave. St., ... Ward)

Registered No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S. If of foreign birth? ..... yrs. ..... mos. ..... ds.

2. FULL NAME Sedonia Hutchins 17

(a) Residence: No. 1031 Argyle Ave St., ... Ward. .....
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

6. If married, widowed, or divorced
HUSBAND of (or) WIFE of Husband's Name Unknown

6. DATE OF BIRTH (month, day, year) April 10 1866

7. AGE 80 Years	Months -	Days 29	If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. General
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Domestic
10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (city or town) (State or country) Md

MOTHER FATHER

13. NAME Unknown
14. BIRTHPLACE (city or town) (State or country) Unknown
15. MAIDEN NAME Jones
16. BIRTHPLACE (city or town) (State or country) Unknown

17. INFORMANT Ethel Hammond
(Address) 1228 Argyle Ave

18. BURIAL, CREMATION, OR REMOVAL
Place Mt. Auburn Date 5-13 1947

19. UNDERTAKER Mrs. Frances A. Hemsley
(Address) 578 N. Riddle Ave

20. FILED MAY 12 1947 Huntington Williams, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) May 9 1947

22. I HEREBY CERTIFY, That I attended deceased from May 1 1947 to May 9 1947
I last saw her alive on May 9 1947 death is said to have occurred on the date stated above, at 7 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Mitral Stenosis and	7
Mitral Regurgitation	

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ..... 19.....
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. .....
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? ..... If so, specify .....

(Signed) John C. Hewitt M. D.
(Address) 6320 Franklin St

OCCUPATION is very important. See instructions on back of certificate.

G51596

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164B

Registered No. G51596

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1532 Light Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George A. Bartholomew

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 11, 1899

8. AGE: Years	Months	Days	If less than one day
48	0	27	hr. min.

9. Birthplace Northampton, Pa.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name August Bartholomew
13. Birthplace ?

MOTHER
14. Maiden Name Sybillla Dietz
15. Birthplace ?

16 (a) Informant Mrs. Elsie Ogle
(b) Address 2812 List Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/13/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

MAY 12 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9, 1947, at 5 P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-9-47 at ? M.
(b) Where did injury occur? Hanover St. Bridge.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Found drowned.

23. Signature Earl L. Royer M.D.
Medical Examiner.
Date signed 5-10-47

51597 Haase

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47a

G51597 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5002 Ross Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5002 Ross Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Franklin Garfield Hall

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Nora Hall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1880

8. AGE: Years	Months	Days	If less than one day
66	5	15	hr. min.

9. Birthplace Balto. Co. Md.
(Town, county, and state)
10. Usual Occupation B.& O. R.R.
11. Industry or business

FATHER
12. Name Charles Hall
13. Birthplace Md.

MOTHER
14. Maiden Name Henrietta ?
15. Birthplace Md.

16 (a) Informant Mrs. Nora Hall
(b) Address 5002 Ross Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/13/47 (month) (day) (year)
(c) Cemetery or crematory Oaklawn
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14.

19 MAY 12 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10th, 1947 at 4 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1946 to May 9 1947 and that I last saw him alive on May 9 1947.

Immediate cause of death	Duration
Emaciation, dehydration, cachexia	
Due to Carcinoma of larynx	9 mos?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Biopsy done about 9 mos ago showing cancer
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Harvey Haase M.D.
Address 5218 Harford Rd. Date signed 5/10/47 M. D.

V S 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51598

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Register No. G51598

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 9 N. Montford Ave
(c) Hospital or institution:
Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore-24
(If outside city or town limits, write RURAL and give town)
(d) Street No. 9.N.Montford Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Catherine Blachowicz

3 (b) If veteran, name war	3 (c) Social Security Account No.
	220-01-0857

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband Joseph
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Nov. 23-1894

8. AGE: Years	Months	Days	If less than one day
52	5	18	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Lipka
13. Birthplace Poland

MOTHER
14. Maiden Name Anna ?
15. Birthplace Unknown

16 (a) Informant Joseph Blachowicz
(b) Address 9 N. Montford Ave

17 (a) Burial (b) Date thereof 5-16-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore, Md.
18 (a) Funeral director George R Weber
(b) Address 805 South Ann Street
19 (a) MAY 12 1947 (b) Thomas J. Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11th 1947, at 11.45 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1945 to May 11 1947.
and that I last saw him alive on May 7 1947.
Immediate cause of death Cerebral Hemorrhage
Due to Hypertensive Cardiovascular Renal Disease.
Other Conditions —
(Include pregnancy within 3 months of death)
Major findings: —
Of operations —
Of autopsy —

Duration
1 min.
4 hours
2 days
7 years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence —
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —
23. Signature [illegible] M. D.
Address 16 Eutaw St. Date signed May 14 1947

VS 3

G51599

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G51599

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3000 Elliott St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3000 Elliott St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fred Moser (or) Frederick Moser

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 7 1874

8. AGE: Years 73 | Months 3 | Days 3 | If less than one day: hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business

FATHER
12. Name Jacob Moser
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Bachman
15. Birthplace Germany

16 (a) Informant Mary A. Moser
(b) Address 3906 Clifton Park Ter.

17 (a) Burial (b) Date thereof 5 13 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4300 Belair Rd

18 (a) Funeral director Mark H. G. Dugdale Co.
(b) Address 37 S. Amity St.

19 (a) MAY 12 1947 Huntington Williams M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/10/47 19 at 9:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John Redcay M.D.
Medical Examiner.
Date signed

VS 151

X

G51600

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1639

Registered No. G51600

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 413 Britton Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 413 Britton Place.
(If rural, give location)
(e) Citizen of foreign country? Britton (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. GELHART Cruikshank STEWART

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widowed

6 (b) Name of husband or wife Julius Walker Stuart
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 18. 1870

8. AGE: Years	Months	Days	If less than one day
76	7	24	hr. min.

9. Birthplace Cecil Co. Md.
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name George Washington Cruikshank
13. Birthplace Cecil Co.

MOTHER
14. Maiden Name Sallie E. Cruikshank
15. Birthplace Cecil Co. Md.

16 (a) Informant Cruikshank Stuart
(b) Address 413 Bretton Place

17 (a) burial (Burial, cremation, or removal) (b) Date thereof May 14. 1947 (month) (day) (year)
(c) Cemetery or crematory Elkton Cemetery
Location Elkton Md.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) MAY 12 1947 (Date filed by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12, 1947, at 8.25 a M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Codeine poisoning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5/11/47 at about 7.45 a M.
(b) Where did injury occur? 413 Bretton Place Baltimore City
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Ingestion of Codeine

23. Signature George W. Merrill M.D.
Medical Examiner.
Date signed 5/20/47

VS 191

G51601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G51601 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenway Aparts.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Greenway Aparts. Charles & 33rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander Myers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Lillie Lucas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3rd. 1888

8. AGE: Years 58 | Months 6 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Merchant marine

11. Industry or business

FATHER
12. Name Joseph A. Myers
13. Birthplace Baltimore

MOTHER
14. Maiden Name Grace MacKay
15. Birthplace N.Y.City

16 (a) Informant Mrs. J.P.Ripley
(b) Address Greenway Aparts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 23. 47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) MAY 12 1947 (Date Rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1947 at 10A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1927 to May 9 1947 and that I last saw deceased alive on May 9 1947

Immediate cause of death: Coronary Thrombosis — Duration: Sudden

Due to: Arterio-Sclerosis — Duration: Gradual

Due to: Myocarditis — Duration: 1 yr.

Due to: Hypertension — Duration:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M.M. Hardy

Address 1603 Park Ave. Date signed 5/12/47

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51602 Bk# b-58917 110267

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

GM 157E

G51602
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern AVE.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 9Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 206 N. Eden St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Snyder, Anna May

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12-1946

8. AGE: Years 0 | Months 6 | Days 25 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Albert Snyder
13. Birthplace MD.

MOTHER
14. Maiden Name Elizabeth Snyder
15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 12 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn Md

18 (a) Funeral director Elroy B. Wilson
(b) Address 1000 Brantley ave

MAY 12 1947 (a) (b) Huntington Williamsport Md.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7- 1947, at 3.20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 28 1947, to May 7 1947, and that I last saw h er alive on May 7 1947.

Immediate cause of death	Duration
Congental heart disease	
a. Transposition of the great	
Due to vessels, coarctation	
of arch of aorta, patent	
Due to ductus arteriosus,	life
ventricular septal defect.	life

Other Conditions Atelectasis, Ch. Emy
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Wilson E. Hughes M. D.
Address Balto City Hosp Date signed May 8 47

VS 150

correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G51603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 131a

G51603 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 727 Catonave.
(c) Hospital or institution: — 91
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 727 Catonave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Eudor Harman

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: John Harman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 11, 1867

8. AGE: Years 94 | Months 8 | Days 29 | If less than one day hr. min.

9. Birthplace Balto. Co. Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George L. Eudor
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Martha Lloyd
15. Birthplace Balto. Co. Md.

16 (a) Informant Mrs. Alda Busch
(b) Address 727 Catonave Balto. Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 13 47 (month) (day) (year)
(c) Cemetery or crematory Mothers Lodge
Location Moxton, Md.

18 (a) Funeral director L. M. Brooks
(b) Address Sparks, Md.

19 (a) [illegible] (b) Filed by registrar Huntington Williams M.D.

MAY 12 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1947, at 2:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1939, to May 10 1947, and that I last saw h.e alive on May 9 1947

Immediate cause of death: Acute pulmonary Edema — Duration: Immediate

Due to Chr. Myocarditis, — Indefinite

Due to Generalized Arteriosclerosis — Indefinite

Other Conditions Chr. Glomerular Nephritis — Indefinite

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature Nathaniel M. Rock M. D.
Address 1008 E. 23rd St Date signed May 12 1947

937

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51604

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G51604 Registered No.

94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3805 Woodbine Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) 1945.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3805 Woodbine Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louise M. Carr

3 (b) If veteran, name war
3 (c) Social Security Account No.

4 Sex Female | 5 Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Joshua Barney Carr

6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) April 14 1878

8. AGE: Years 69 | Months 1 | Days 00 | If less than one day hr. min.

9. Birthplace Fredericksburg Va
(Town, county, and state)

10. Usual Occupation Nurse

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant E. G. Vanden Bosche
(b) Address 1528 Bolton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 13/47 (month) (day) (year)
(c) Cemetery or crematory Green Mount Cem
Location Baltimore Md.

18 (a) Funeral director Fidelity Funeral
(b) Address 1510 Liberty Heights Ave

19 (a) (b) Date received by registrar MAY 12 1947 Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1947, at 8 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 1947, to May 11 1947, and that I last saw h alive on May 11 1947.

Immediate cause of death Coronary Occlusion

Due to Generalized Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos. J. Gilbert M.D.

Address 1509 Liberty Heights Ave Date signed May 12/47

X

G51605

514193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

G51605

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ga (b) County
(c) City or town Coffee
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Robert Dixon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-7-44

8. AGE: Years 3 | Months 3 | Days 5 | If less than one day hr. min.

9. Birthplace Ga (town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Doyle M Dixon

13. Birthplace Ga

MOTHER 14. Maiden Name Lovie Turner

15. Birthplace Ga

16 (a) Informant JOHNS HOPKINS HOSPITAL Records

(b) Address

17 (a) Burial (b) Date thereof MAY 12. 47 (month) (day) (year)

(c) Cemetery or crematory DAMASCUS Church

Location COFFEE. Ga.

18 (a) Funeral director John. O. Mitchell & Son

(b) Address 1900 Eutaw place

19 (a) (b) (Date received by registrar) Huntington Hill Registrar, M.D.

MAY 12 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1947 at 2 35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 25 1947 to May 12 1947 and that I last saw h alive on May 12 1947

Immediate cause of death	Duration
Cardiac failure	
Due to Congenital heart disease	Life
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 4/25/47

Major findings of operation:

of autopsy Transposition great vessels

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry F. Bahnson M.D.

Address JHH Date signed 5/12/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51606

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 107

Registered No. G51606

DC# 64764 2

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 202 N. Fremont Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carl David French Frank ✓

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1946

8. AGE: Years	Months	Days	If less than one day
	11	27	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William J. Franke
13. Birthplace Laurinda, S C.

MOTHER
14. Maiden Name Elizabeth Clark
15. Birthplace Statesville, N C

16 (a) Informant William J. Franke
(b) Address 202 N. Fremont Ave

17 (a) Burial (b) Date thereof May 12, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St

MAY 13 1947 Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-8- 1947, at 6 30 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D.
Medical Examiner.
Date signed 5-9-47

VS 191

X

G51607

BALTIMORE CITY HEALTH DEPARTMENT

BC# D77845 CERTIFICATE OF DEATH V161a

Registered No. G51607

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wolkens & Calow Aves
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Glyndon Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Guyton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-6-47

8. AGE: Years | Months | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore - Md.
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Charles T Guyton
13. Birthplace Md.

MOTHER
14. Maiden Name Audrey Smith
15. Birthplace Wash. D.C.

16 (a) Informant Mr Charles T. Guyton
(b) Address 1200 Glyndon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/13/47 (month) (day) (year)

(c) Cemetery or crematory Woodlawn
Location Sparrows Pt. Md.

18 (a) Funeral director Tyler & Bowers Co
(b) Address 1103 Eutaw St.

MAY 13 1947

(a) (Signature of registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1947, 10:35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-6 1947 to 5-12 1947, and that I last saw h[illegible] alive on 5-12 1947.

Immediate cause of death Asphyxia

Due to Aspirated vomitus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stuart D. Ashpea M.D.
Address St Agnes Hosp Date signed 5/12/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G51608

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2239 E. Biddle Street
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) –

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town 2239 E. Biddle Street
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore, Maryland
(If rural give location)
(e) Citizen of foreign country? – (Yes or No)
If yes, name country

3 (a) FULL NAME Timothy Patrick Morrison

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 214 03 2316

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 9, 1884

8. AGE: Years 62 | Months 5 | Days 3 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Bar Tender
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Ireland

MOTHER
14. Maiden Name Unknown
15. Birthplace Ireland

16 (a) Informant Mrs. Clara E. Ford
(b) Address 2029 W. Cold Spring Lane

17 (a) Buairl (Burial, cremation, or removal) (b) Date thereof May 14-47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

MAY 13 1947 (Date rec'd by registrar) Lexington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1947, 1:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 1947 to May 12 1947 and that I last saw him alive on May 10 1947.

Immediate cause of death: Coronary Thrombosis — Duration

Due to — Duration

Due to — Duration

Other conditions: Arteriosclerosis, Hypertension, Myocarditis — Duration
(Include pregnancy within 3 months of death)

Date of operation –
Major findings of operation: –
of autopsy: –

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide –
(b) Date of occurrence – at M
(c) Where did injury occur? – (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? – (Specify type of place) While at work?
(e) Means of injury

23. Signature John A. Schwenck, M.D.
Address 1337 S. Charles St. Date signed 5/12/47

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The ... should be carefully supplied.

G51609

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G51609

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St. Balto Md.
(c) Hospital or institution:
Little Sisters of the Poor.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 88 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 837 N. Eutaw St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George C. Vansant

3 (b) If veteran, name war: no
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 12, 1859.

8. AGE: Years 88 | Months 3 | Days 29 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name Joseph Vansant
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Ella White
15. Birthplace Philadelphia

16 (a) Informant Little Sisters of the Poor.
(b) Address 1200 Valley St.

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 5/14/47 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.
(c) MAY 13 1947 Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11th 1947 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1- 1947 to May 11- 1947 and that I last saw him alive on May 10- 1947

Immediate cause of death	Duration
Edema of Lungs	10 day
Due to Chronic Myocarditis	5 yrs
Other Conditions Arteio Sclerosis	10 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1631 E North Av Date signed 5/12/47

VS 150

correct age is especially important. Physicians: please

X

51610

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G51610 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5527 Belair Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5527 Belair Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry W. Bauer

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-10-3875

4. Sex Male | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Margaret C. Bauer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17-1908

8. AGE: Years 38 | Months 10 | Days 24 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business Salesman

FATHER 12. Name Edw. J. Bauer

13. Birthplace Md.

MOTHER 14. Maiden Name Catherine Berger

15. Birthplace Md.

16 (a) Informant Margaret C. Bauer

(b) Address 5527 Belair Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-14-47 (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location Baltimore

18 (a) Funeral director Philip Henry Sons

(b) Address 2024 Orleans St.

19 (a) MAY 13 1947 (Date received by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1947 at 10 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1947 to May 11 1947 and that I last saw him alive on May 9, 1947.

Immediate cause of death: Abdominal neoplasm — Duration 9 mos.

cause undetermined

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature W. H. Krenger

Address 1402 Eutaw Pl. Date signed 5-13-47

VS 150

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G51611

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G51611

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1415 Linden Ave
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ✓
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1415 Linden Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mathilda Bowie Robbins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 31 1868

8. AGE: Years	Months	Days	If less than one day
78	8	12 11	hr. min.

9. Birthplace Michigan (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name ? Robbins

13. Birthplace unknown

MOTHER 14. Maiden Name Alice Bowie

15. Birthplace Md.

16 (a) Informant Mrs. Robert Wilson Oates

(b) Address 121 N. Lanvale St - 17

17 (a) Cremation (b) Date thereof May 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Greenmount

Location Balto Md

18 (a) Funeral director Henry H. Jenkins & Sons

(b) Address McCulloh & Orchard Sts

19 MAY 13 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1947, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 8 1947 to May 11 1947, and that I last saw h. alive on May 10 1947.

Immediate cause of death: chronic nephritis — Duration: several years

Due to: arteriosclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operations:

of autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold P. Smith, Jr. M.D.

Address 1014 St Paul St. Date signed 5/12/47.

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51612

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G51612

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs. 15 m. 14
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1431 Argyle Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Neal Allen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	N	Married

6 (b) Name of husband or wife Pearl Allen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1902

8. AGE: Years	Months	Days	If less than one day
45			hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Pearl Allen
(b) Address 1431 Argyle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/14/47 (month) (day) (year)
(c) Cemetery or crematory Mt Cuba
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Lewis Lee Ave.

19 (a) MAY 13 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/11 1947, at 3.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/11 1947 to 5/11 1947 and that I last saw h. i.m. alive on 5/11 1947

Immediate cause of death Cerebral Apoplexy — Duration

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address [illegible] Date signed 5-14-47

VS 150

PRESS WRITE FIRMLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age in especially important. Physicians: please write the causes of death clearly and legibly.

G51613

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V.13B

Register No. G51613

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT WITH PENCIL, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1512 N. Eden St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Bagley
3 (b) If veteran, name war
3 (c) Social Security Account No. 216-09-5520
4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Matilda Bagley
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 5/7/1886
8. AGE: Years 61 62 Months — Days 65 If less than one day hr. min.
9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Farmhand PT Ind
11. Industry or business

FATHER
12. Name Anderson Bagley
13. Birthplace Weathersfield Va

MOTHER
14. Maiden Name Eliza A. Scott
15. Birthplace Weathersfield Va

16 (a) Informant Matilda Bagley
(b) Address 1512 North Eden St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 15-1947 (month) (day) (year)
(c) Cemetery or crematory Antietam Memorial PK
Location Antietam Md

18 (a) Funeral director Robert D. Williams
(b) Address 1515 McCulloh St

19 (a) MAY 13 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/12 1947, at 3:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/7 1947, to 5/12 1947, and that I last saw h[illegible] alive on 5/12 1947.

Immediate cause of death Miliary Tuberculosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. Williams M. D.
Address Home Hosp Date signed 5/12/47

VS 150

Diers

G51614

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G51614 / 4812

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St Josephs
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 wks
(e) Length of stay in Baltimore (yrs., mos., or days) 68 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 211 E Federal St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Jennie B. Diers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Herman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6 | 25 | 78

8. AGE: Years	Months	Days	If less than one day
68	10	17	hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Thomas
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mr Herman Diers
(b) Address 211 E Federal St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-15-47 (month) (day) (year)

(c) Cemetery (or crematory) Oak Lawn
Location Gaylord Ave & Milly Ln

18 (a) Funeral director John E. Slinde St
(b) Address 243

19 MAY 13 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 | 12 | 47 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/25 1947 to 5/12 1947 and that I last saw h[illegible] alive on 5/12 1947

Immediate cause of death	Duration
Cardiac insufficiency	
Due to Hypertensive C-V Heart Disease & Gen. Arteriosclerosis	
Due to	
Other Conditions Carcinomatosis	over

(Include pregnancy within 3 months of death)

Date of operation 4/26/47

Major findings of operation: Carcinomatosis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Arthur J. Olsen M.D.
Address St Josephs Date signed 5/14/47

X

VS 150

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. Use black ink. Do not write figures in words. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G51615

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133a

Registered No. G51615

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1434 Belvedere St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 1434 Belvedere St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Seath

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Blanche

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1905

8. AGE: Years	Months	Days	If less than one day
41 40	8	3	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Robert L. Seath Sr.
13. Birthplace Virginia

MOTHER
14. Maiden Name Marie Thomas
15. Birthplace Virginia

16 (a) Informant Mrs. Pryor
(b) Address 2609 Bolton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 15, 47 (month) (day) (year)
(c) Cemetery or crematory M.F. Calvary
Location Maryland Ave. & N. Ave.

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St.

19 (a) MAY 13 1947 (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-11- 1947, at M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Cystitis &
Pyonephrosis, left.
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D. (Medical Examiner)
Date signed

VS 151

G51616 G51616

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No.

PRINT in INK if pencil, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 da
(e) Length of stay in Baltimore (yrs., mos., or days) 13 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2550 McCullough St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Inocencio, Ann

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Mar.

6 (b) Name of husband or wife Joe Inocencio
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) unkn

8. AGE: Years	Months	Days	If less than one day
33			hr. min.

9. Birthplace Philadelphia, Pa.
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Records unknown
13. Birthplace

MOTHER
14. Maiden Name Martha Coles
15. Birthplace Norfolk, Va.

16 (a) Informant Records
(b) Address U. S. Marine Hospital

17 (a) Burial (b) Date thereof 5-14-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location a. G. Co

18 (a) Funeral director Joyner Sandifer
(b) Address 1417 E. Preston St.

19 (a) Date received (b) Registrar's signature MAY 13 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11, 1947, at 6:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 29, 1947 to May 11, 1947, and that I last saw her alive on May 10, 1947.

	Duration
Immediate cause of death Acute pulmonary edema	20 hrs
Due to Cardiac decompensation	unk
Due to hypertension	unk
Other Conditions Uremia	unk

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operations
of autopsy none performed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James T. Hearin
James T. Hearin M. D.
Address Univ. Balto., Md. Date signed 5/11/47

VS 150

C51617 — EMMA M.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH — 95c

Registered No. C51617

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Raynor Ave & Dukeland St.
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1658 E. 25th. St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Mrs. Emma W. Sparks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Finley H. Sparks

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 11, 1881

8. AGE: Years 66 | Months 2 | Days 29 | If less than one day hr. min.

9. Birthplace: Maryland (town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: William H. Smith
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Ida M. Duncan
15. Birthplace: Kent Co. Md.

16 (a) Informant: Mr. Finley H. Sparks
(b) Address: 1658 E. 25th St. Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 14-1947 (month) (day) (year)
(c) Cemetery or crematory: Glenwood Cem. Wash. D. C.
Location: Washington D. C.

18 (a) Funeral director: Mamie E. Syfer.
(b) Address: 1600 W. North Ave

19 MAY 13 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 10, 1947, at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 29, 1947 to May 10, 1947 and that I last saw he alive on May 10, 1947

Immediate cause of death: Cardio-respiratory failure

Due to: Cardio-vascular accident

Due to: Arteriosclerosis

Other Conditions: Chronic cardiac decompensation

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Leon Toby M.D.

Address: West Balto. Gen. Date signed 5/10/47

Resp. X

VS 190

Please write the causes of death clearly and legibly. Physicians: please correct age is especially important. Physicians: please

651618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √50

G51618 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3708 Chestnut Ave.
(c) Hospital or institution: 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, 1
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3708 Chestnut Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rita Rizzo Dente

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female

5. Color or race white

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Albert F. Dente

6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) 4/20/1907

8. AGE: Years 40 | Months -- | Days 22 | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Anthony Rizzo
13. Birthplace Italy

MOTHER
14. Maiden Name Cecelia Cemena
15. Birthplace Italy

16 (a) Informant Albert F. Dente
(b) Address 3708 Chestnut Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/14/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Frederick Road, Balto. Md.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 MAY 13 1947 (Date filed by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-31 1947, to 5-12 1947, and that I last saw h. alive on 5-11 1947.

Immediate cause of death Pericarditis — Duration 2 days

Due to Pleurisy pneumonia + Hydrothorax — 1 mo + 12 days

Due to

Other Conditions Dropsy Carcinoma of left breast — abt 2 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S. D. Emerick M. D.
Address Medical Arts Bldg. Date signed

VS 150

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied. correct age is especially important.

G51619

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G51619

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital since 5/9/47
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1933 W. Mulberry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William J Kroeger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Emma J

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 31 1875

8. AGE: Years 72 | Months 7 | Days 11 | If less than one day hrs. min.

9. Birthplace Balto Md
(Town, county, or state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Bernard Kroeger

13. Birthplace Germany

MOTHER 14. Maiden Name Elizabeth Wolf

15. Birthplace Germany

16 (a) Informant Emma J Kroeger

(b) Address 3409 Eaton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-14-47 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore Md

18 (a) Funeral director George C Fahey

(b) Address 700 Cathedral St Fayette

19 MAY 13 1941 (Date rec'd by registrar) Huntington-Williamson Mills Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/11 1947, at 12 20 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5/9/47 at about 3 00 P M. 21/1
(b) Where did injury occur? 1933 W. Mulberry St
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury fell down front steps

23. Signature G F J Schmidt M.D.
Medical Examiner.
Date signed 5/12/47

VS 191

C51620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

Registered No. C51620

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Morgue
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 915 S. Clarke St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John E. Smith, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1938

8. AGE: Years	Months	Days	If less than one day
9			hr. min.

9. Birthplace Baltimore, MD
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name John Edgar Smith
13. Birthplace St Mary's Co.

MOTHER
14. Maiden Name Evelyn E Smith
15. Birthplace Baltimore, MD.

16 (a) Informant Mrs. Minnie Clay
(b) Address 917 S. Charles St.

17 (a) Burial (b) Date thereof 5/14/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Old Frederick Rd.

18 (a) Funeral director John F. Denny, Inc
(b) Address 715 Light St.

19 (a) MAY 13 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/11 1947, at 6 P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Drowning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 25/6
(a) Date of injury Between 5/4/47 & 5/11/47 ? M.
(b) Where did injury occur? Recovered in Harbor at Locust Point
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Found drowned.

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 5/12/47

VS 151

X

G51621

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G51621

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15 E. York St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 15 E. York St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dora Grabill

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widowed

6 (b) Name of husband or wife Preston Grabill
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) April, 1892

8. AGE: Years	Months	Days	If less than one day
55	1		hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Unknown
13. Birthplace unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant William F. Ritter
(b) Address 813 Glintwood Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/ (month) /47 (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd.

18 (a) Funeral director John F. Denny Inc.
(b) Address 7 E. Eight St.

19 (a) MAY 13 1947 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12th 1947, at 8 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 3 1947 to May 12 1947 and that I last saw h[illegible] alive on May 12 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	9 days
with Right Hemiplegia	
Due to Hypertensive Cardiovascular Disease	Undetermined
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alfred Cole M.D.
M. D.
Address 1934 Wilkens Ave Date signed 3-12-47

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51622

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G51622

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner ave + Oakland St
(c) Hospital or institution: Mt Bait Gen. Hosp
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 4
(e) Length of stay in Baltimore (yrs., ~~mos., or days~~) 72

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 420 N. Hilton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Frederick D. Mathews

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or (wife) Mamie N. Mathews
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 26, 1874

8. AGE: Years 72 | Months 7 | Days 16 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business KoppersCo.

FATHER
12. Name Frank V. Mathews
13. Birthplace Germany

MOTHER
14. Maiden Name Annie Trautmann
15. Birthplace Cumberland, Md.

16 (a) Informant Hospital Records
(b) Address Mt Baltimore Gen. Hosp.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/16/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAY 13 1947 (Date rec'd by registrar) (b) Thurlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11, May 1947, at 11:50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7, May 1947, to 11 May 1947, and that I last saw him alive on 11 May 1947.

Immediate cause of death: Peripheral circulatory failure — Duration:

Due to Cardio-Respiratory Failure

Due to Arteriosclerotic Coronary Artery Heart Dis.

Other Conditions Diabetes mellitus Diabetic Gangrene.
(Include pregnancy within 3 months of death)

Date of operation 11 May 47

Major findings of operation: Diabetes Gangrene Left foot.

of autopsy Arteriosclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry T. Finigan M.D. M. D.
Address Mt Balt Gen Hosp Date signed 5-12-47

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51623

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V/31a

Registered No. G51623

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3405 Okenshaw Place
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3405 Oakenshaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY E. EDWARDS

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Brice W. Edwards
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1, 1859

8. AGE: Years	Months	Days	If less than one day
87	11	10	hr. min.

9. Birthplace Albemarle Co., Va.
(Town, county, and state)
10. Usual Occupation -
11. Industry or business -

FATHER
12. Name Schuyler Marshall
13. Birthplace Va.

MOTHER
14. Maiden Name Ann Eliza Woody
15. Birthplace Va.

16 (a) Informant Mr. Hunter Edwards
(b) Address 319 Suffolk Rd.

17 (a) Burial (b) Date thereof 5/13/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAY 13 1947 Huntington Williams, M.D.
(Date received by Registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11, 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2 1947 to May 11 1947 and that I last saw h[illegible] alive on May 11 1947

Immediate cause of death	Duration
Chron Glomerul Nephritis	1940
Chron Myocarditis	1940
Due to	
Due to	
Other Conditions Arteriosclerosis	1947

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. W. Braly M. D.
Address 503 Charles Date signed May 12 1947

VS 150

G51624

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G51624 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2876 Woodbrook Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2876 Woodbrook Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CARRIE E. ISAACS

3 (b) If veteran, name war: no

3 (c) Social Security Account No.:

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: I. Michael Isaacs

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1864

8. AGE: Years 82 | Months 8 | Days 1 | If less than one day hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Matthews
13. Birthplace Snow Hill, Md.

MOTHER
14. Maiden Name Amelia Laib
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. I. Michael Isaacs
(b) Address 2876 Woodbrook Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/13/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAY 13 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11, 1947, at 10:30a M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1947 to May 11 1947, and that I last saw h[illegible] alive on May 10 1947.

Immediate cause of death: Arteriosclerotic Heart Disease — Duration

Due to

Due to

Other Conditions: Pulmonary Tuberculosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Morris M. Steinberg M.D.

Address 416 N Milton St Date signed May 13 1947

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

937

G51625

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 5/13

G51625 Registered No.

Please write plainly in ink or use typewriter. Information must be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 605 EAST 34TH STREET.
(c) Hospital or institution:
NONE 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) NONE
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 605 EAST 34th STREET.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES L HALL.

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Susan M. Hall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 7, 1867

8. AGE: Years	Months	Days	If less than one day
79	8	4	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Central Metal & Supply Co.

FATHER
12. Name John Hall
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Mary Fusselbaugh
15. Birthplace Balto., Md.

16 (a) Informant Mr. Irving P. Hall
(b) Address 4212 Loch Raven Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/14/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAY 13 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 11 1947 19 , at 10.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from NOV 25 1946 , to MAY 11 1947 , and that I last saw him alive on MAY 11 1947

Immediate cause of death	Duration
ACUTE CARDIAC DILITATION MAY	11 1947
Due to CARCINOMIA PROSTATE APRIL	1945.
Due to METASTASSIS	1946
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation APRIL 1945.
Major findings of operation: CARCINOMIA PROSTATE.
of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul A. Blanton M. D.
3013 ST PAUL ST Address MAY 11 1947. Date signed

VS 150

G51626

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G51626 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2309 Roslyn Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2309 Roslyn Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph SANFORD Williams, Sr.

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Helen Williams (nee Morris) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 30, 1899

8. AGE: Years	Months	Days	If less than one day
98	1	10 11	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Milton B. Williams
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary E. Spranklin
15. Birthplace Baltimore

16 (a) Informant Mrs. Helen V. Williams
(b) Address 2309 Roslyn Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/13/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAY 13 1947 (Date rec'd by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/10/47 19 , at 12:45 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Dawe M.D.
Medical Examiner.
Date signed 5/10/47

VS 151

G51627

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

Registered No. G51627

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 D
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1700 E. 31st St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME ROBERT Lee VONDERSMITH

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife -
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 9, 1886

8. AGE: Years	Months	Days	If less than one day
61	0	2	.....hr. .....min.

9. Birthplace Reisterstown, Md. (Town, county, and state)
10. Usual Occupation.....
11. Industry or business

FATHER
12. Name Daniel Vondersmith
13. Birthplace Lancaster, Pa.

MOTHER
14. Maiden Name Maria Umphries
15. Birthplace Reisterstown, Md.

16 (a) Informant Mrs. Eva B. Combs
(b) Address 1700 E. 31st St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/15/47 (month) (day) (year)
(c) Cemetery or crematory Lutheran Cem.
Location Reisterstown, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
Address Baltimore, Md.

19 (a) MAY 13 1947 (Date rec'd by registrar) Washington Metropolitan Region

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/11/47 19..... at.....M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature John R. Davis M.D. Medical Examiner.
Date signed 5/12/47

VS 151

G51628

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G51628 178 a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2000 Orleans St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME IRENE M. REA

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 8, 1875

8. AGE: Years	Months	Days	If less than one day
71	7	2	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Branch Manager
11. Industry or business Regal Laundry

FATHER
12. Name Joseph B. Rea
13. Birthplace unknown

MOTHER
14. Maiden Name Martha B. -
15. Birthplace Unknown

16 (a) Informant Mr. James W. Atkinson, Jr.
(b) Address 1702 Braddish Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/14/47 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) MAY 13 1947 (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10, 1947, at 10 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Carbon monoxide poisoning.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-10-47 9.55 A.M.
(b) Where did injury occur? 2008 Orleans St. Baltimore, Md.
(c) Did injury occur at home on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Gas escaped from radiator

23. Signature George S. Merrill M.D.
Medical Examiner.
Date signed 5/10/47

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G51629

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V175a

Registered No. G51629

Please write the causes of death clearly and legibly. Physician: please write legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2320 Druid Hill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William E. GITTINGS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Elsie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26, 1875

8. AGE: Years 72 | Months 0 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name Wm. N. Gittings
13. Birthplace Balto. Co.

MOTHER
14. Maiden Name Rachael Talbott
15. Birthplace Balto. Co. Md.

16 (a) Informant Mrs. Florence Robinson
(b) Address 2325 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 13, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Md.

18 (a) Funeral director Wm. Lyes A. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) MAY 13 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 1947, at 1:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Bronchopneumonia
Myocardial degeneration
Due to Fractured ribs

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5/1/47 at Harford Co. Md. M.
(b) Where did injury occur? Jarrettsville, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Farm While at work? yes
(d) Means of injury tractor

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 5-10-47

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G51630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 1319

Registered No. G51630

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 312 N. Calhoun St. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Jamaica, B.W.I.

3 (a) FULL NAME Frances Jamieson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Married

6 (b) Name of husband or wife Frederick Jamieson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 28, 1884

8. AGE: Years	Months	Days	If less than one day
63	0	11	hr. min.

9. Birthplace Jamaca British W. Indies (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name John Grandison
13. Birthplace British West Indies

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Frederick Jamieson
(b) Address 312 N. Calhoun St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 13, 1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Miss Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) MAY 13 1947 (b) Huntington Williams (Registrar)

VS 199

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 1947, at 8 3/4 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 28 1947, to May 9 1947, and that I last saw her alive on May 9 1947.

Immediate cause of death Cerebral Accident — Duration 11 days

Due to Hypertensive Cardio-Vascular Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard C. Smith M. D.
Address 1514 Division St. Date signed 5-12-47

651631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 13B

Registered No. 651631

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1434 N. Mount St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Hood.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Hattie Hood.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-18-1899

8. AGE: Years 47 45 | Months 7 | Days 22 | If less than one day hr. min.

9. Birthplace Greenville - S.C.
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Benjamin Hood
13. Birthplace Greenville - S.C.

MOTHER
14. Maiden Name Sarah Sherred
15. Birthplace Greenville - S.C.

16 (a) Informant Mrs. Hattie Hood
(b) Address 1434 N. Mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-14-47 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem.
Location Arbutus - Md

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St

19 (a) MAY 13 1947 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-10 1947 at 10:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-25 1947, to 5-10-1947, and that I last saw him alive on 5-10-1947

Immediate cause of death Shock due to Hemoperitoneum postoperative. — Duration

Due to Chronic Myeloid Leukemia
Tuberculosis (Tabetic pulmonary)

Due to Cirrhosis Liver.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Oskar Ratzersdorfer Jenkins M.D.
M. D.
Address University Hospital Date signed 5-10-47

VS 150

correct age is especially important. Physicians: please write the

G51632

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No. G51632

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 309 Loneys Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 309 Loneys Lane (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country - - - -

3 (a) FULL NAME Jennie E. Deinlein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1877

8. AGE: Years 69 | Months 10 | Days 8 7 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Seamstress

11. Industry or business Sewing

FATHER
12. Name John Frederick
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Giebhardt
15. Birthplace Germany

16 (a) Informant John Frederick Deinlein
(b) Address 214 N. Ellwood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-14-1947 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cemt.
Location German Hill Rd., Balto.

18 (a) Funeral director Lilly & Zeibe Inc.
(b) Address 403 S. Wolfe Street

19 (a) MAY 13 1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1947, at 9 30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 6 1947, to May 11 1947, and that I last saw h-er alive on May 10 1947

Immediate cause of death ventricular fibrillation — Duration 6 days

Due to coronary thrombosis.

Due to

Other Conditions hypertension arteriosclerosis.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. Oddstad M.D.
Address 447 N. Kenwood Ave Date signed 5/13/47

VS 190

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C51633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163

C51633 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6205 Gist Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) 3 Mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6205 Gist Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helena Schneider

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Jacob

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 70 | Months | Days | If less than one day: hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER — 12. Name unknown
13. Birthplace Germany

MOTHER — 14. Maiden Name unknown
15. Birthplace Germany

16 (a) Informant Norman Gundberg
(b) Address 6205 Gist Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof V-13-47 (month) (day) (year)
(c) Cemetery or crematory Fort Carroll
Location Germany Hill Rd

18 (a) Funeral director Fort Lawn Funeral Home
(b) Address 1439 E. Baltimore St.

19 MAY 13 1947 (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH V-12- 1947, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1947 to V-12 1947, and that I last saw her alive on May 9 1947.

Immediate cause of death: Coronary thrombosis — Duration: 1 hour

Due to: Arteriosclerosis — 1 years

Due to:

Other Conditions: Toxic Goiter — 6 Months

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alan Bernstein M.D.

Address 1109 N Calvert St Date signed 5/14/47

VS 150

X

G51634

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

G51634 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument
(c) Hospital or institution: Jewish Hospt 3rd
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1010 E. Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUIS WEINSTEIN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Solomon
13. Birthplace Russia

MOTHER
14. Maiden Name Rang
15. Birthplace Russia

16 (a) Informant Benj Weinstein
(b) Address 1401 York Rd

17 (a) Burial (b) Date thereof 5-13-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Harford Rd & York Rd

18 (a) Funeral director Jacob Louis Levy
(b) Address 1439 E. Baltimore St.

19 (a) MAY 13 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 12 1947, at 10:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from MAY 4 1947 to 5/12/47 19..., and that I last saw h... alive on 5/12/47 19...

Immediate cause of death Uremia — Duration 8 days

Due to Pyelonephritis — 8

Due to Cancer of Bladder

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arthur Hollander M. D.
Address Sinai Hospital Date signed 5/14/47

X

Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

G51635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G51635

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 905 E. Fayette St
(c) Hospital or institution:
51
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 905 E Fayette St (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abram Berman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Annie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 61 67 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county and state)

10. Usual Occupation accountant

11. Industry or business

FATHER 12. Name Isaac

13. Birthplace Russia

MOTHER 14. Maiden Name Lena

15. Birthplace Russia

16 (a) Informant Annie Berman

(b) Address 905 E. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-14-47 (month) (day) (year)

(c) Cemetery or crematory Har Sinai

Location Eastern Ave

18 (a) Funeral director Jerk Levin Inc

(b) Address 2100 Eutaw Place

19 (a) (D— MAY 13 1947 by — Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-13- 1947, at 1A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1929, to May 9 1947, and that I last saw h.l.m. alive on May 9 1947.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Hypertensive Cardio-Vascular Disease	8y
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Wasserman M. D.
Address 1401 Eutaw Place Date signed May 13, 1947

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51636

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G51636

Every item of information should be carefully supplied. Typewrite or write the cause of death clearly and legibly. Physicians: please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring Ave
(c) Hospital or institution: Levendale
(d) Length of stay in hospital or inst. (yrs., mos., or days) 33 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Levendale (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Yetta Feldman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Israel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1863

8. AGE: Years: 84 | Months | Days | If less than one day: hr. min.

9. Birthplace: Poland (Town, county, and state)

10. Usual Occupation: Midwife

11. Industry or business

FATHER
12. Name unknown
13. Birthplace Poland

MOTHER
14. Maiden Name unknown
15. Birthplace Poland

16 (a) Informant: Louis Feldman
(b) Address: 1904 E. Balto St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-14-47 (month) (day) (year)
(c) Cemetery or crematory
Location: Hebrew Mt Carmel

18 (a) Funeral director: Jack Lewis Co
(b) Address: 1459 E Balto St

19 MAY 13, 1947 (b) Remington for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12 1947, at P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-1 1930 to 5-12 1947, and that I last saw h alive on 5-12 1947.

Immediate cause of death	Duration
Hypertension	
Cer. card. vascular disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: H Edmund Levin M.D.
Address: Levindale Date signed 5/15/47

VS 150

C51637

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C51637

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor Ave & Dukeland St
(c) Hospital or institution: West Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3500 Virginia Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Morris Gerber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Rebecca

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 12, 1874

8. AGE: Years 73 | Months 3 | Days 1 | If less than one day hr. min.

9. Birthplace Lech, Europe (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER — 12. Name Nachman

13. Birthplace Lech

MOTHER — 14. Maiden Name Ida

15. Birthplace Lech

16 (a) Informant Rebecca Gerber

(b) Address 3500 Virginia Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-13-47 (month) (day) (year)

(c) Cemetery or crematory Mt Carmel

Location Nethrew

18 (a) Funeral director Jack Levin Inc

(b) Address 1534 E Balto St

19 (a) (b) Thurlington Williams, M.D. Registrar

MAY 13 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1947 at 1:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 11 1947 to May 13 1947 and that I last saw him alive on May 13 1947.

Immediate cause of death: ~~Coronary Thrombosis~~ Myocardial Infarction — Duration: 7 Days

Due to: Coronary artery disease — 7 years?

Due to: arteriosclerosis — ?

Other Conditions: arteriosclerosis obliterans.

(Include pregnancy within 3 months of death)

Date of operation: NO Operation

Major findings of operation:

of autopsy: NO AUTOPSY

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature D. F. Gleason M. D.

Address 2834 St Paul St Balto Date signed May 13, 47

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any false statement, omission or concealment of facts called for on this certificate may subject the informant to prosecution and punishment by fine or imprisonment or both. Please write carefully supplied. The

X

C51638

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

C51638 Registered No.

AB-110191

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore, City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16days
(e) Length of stay in Baltimore (yrs., mos., or days) 58yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Green (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Golenbieski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Div.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15- 1888

8. AGE: Years 58 | Months 8 | Days 26 | If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Golenbieski
13. Birthplace Poland

MOTHER
14. Maiden Name Lena Jagaeski
15. Birthplace Poland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 14/47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Ozazewski
(b) Address 1936 Eastern Ave

19 (a) MAY 13 1947 Huntington Williams M.D.
Registrar

MEDICAL CERTIFICATION PM

20. DATE OF DEATH May 11- 1947 at 4.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-25- 1947 to 5-11- 1947 and that I last saw him alive on 5-11- 1947

	Duration
Immediate cause of death: Shock due to Esophageal hemorrhage	2 hrs
Due to Ca. Cell Ca of Esophagus	6-8 Mo.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 4-30-47
Major findings of operation: Gastrostomy
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H Bruller M. D.
Address City Hosp Date signed 5-12-47

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51639

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √46 B

G51639 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2642 Brune St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 1
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Maryland (If outside city or town limits, write RURAL and give town)
(d) Street No. 2642 Brune St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lizzie Brogden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife James Brogden

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6, 1906

8. AGE: Years 40 | Months 11 | Days 11 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER 12. Name Archie Boyd

13. Birthplace Virginia

MOTHER 14. Maiden Name Anna Boyd

15. Birthplace Virginia

16 (a) Informant Lizzie Brogden

(b) Address 2642 Brune St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/15/47 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet Cemetery

Location Anne Arundel County, Md.

18 (a) Funeral director Joyner Sanders

(b) Address 1417 E. Fayette St

(c) MAY 13 1947 (Date rec'd by registrar) (b) Huntingtown Williams, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-12-47 19 , at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-12-43 19 to 5-12-47 19 , and that I last saw her alive on 5-11-47 19

Immediate cause of death	Duration
Myocardial failure	2 days
Due to Gastro Carcinoma	4 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. Edwin M. D.

Address 238 N Conkling Date signed 5-13-47

correct age is especially important. Physicians: please write clearly and legibly.

G51640

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 307

Registered No. G51640

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 5W
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1423 Jefferson St (Or rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lizzie McDougle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age 94 years

7. Birth date of deceased (mo., day, yr.) 4-20-02

8. AGE: Years 45 | Months - | Days 20 | If less than one day ... hr. ... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Junk Dealer

11. Industry or business

FATHER 12. Name John McDougle

13. Birthplace N. C.

MOTHER 14. Maiden Name Mary McDougle

15. Birthplace N. C.

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Shipple (Burial, cremation, or removal) (b) Date thereof 5/14/1947 (month) (day) (year)

(c) Cemetery or crematory

Location Fayetteville, N. C.

18 (a) Funeral director Rayner Saunders

(b) Address 1412 E. Preston St.

19 (a) ... (b) ...

(Date received by registrar) Registrar

MAY 13 1947

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10th 1947, at 8:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 1947 to May 10 1947 and that I last saw him alive on May 10 1947.

Immediate cause of death Dissecting aortic aneurysm & rupture — Duration 6 hours

Due to aortic insufficiency

Due to Syphilis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 0

Major findings of operation:

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. J. Hamby, M.D.

Address Johns Hopkins Hosp. Date signed 5-10-47

For R. R. Dawis, by Hamby M.D.

X

Medicine M.D.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51641

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

Registered No. G51641

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 954-Forrest St
(c) Hospital or institution: Maryland Penitentiary Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mo 28 da
(e) Length of stay in Baltimore (yrs., mos., or days) ??

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Fredericksburg Va
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Willie Parker #2

3 (b) If veteran, name war ??
3 (c) Social Security Account No. ??

4. Sex Male | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/16/1915

8. AGE: Years 32 | Months 1 | Days 22 | If less than one day hr. min.

9. Birthplace Fredericksburg, Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Eddie Parker
13. Birthplace Fredericksburg, Va

MOTHER
14. Maiden Name Winnie Dabney
15. Birthplace Fredericksburg, Va.

16 (a) Informant Maryland Penitentiary Records
(b) Address 954- Forrest St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 13 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location Brooklyn Md

18 (a) Funeral director Elroy D. Wilson
(b) Address 1019 Betterton Md

19 (Date rec'd by registrar) MAY 13 1947 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 1947 at 4:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 17 1947, to May 8 1947, and that I last saw him alive on May 8 1947.

Immediate cause of death	Duration
Congestive heart failure	
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John F. Anderson M. D.
Address Md. Penitentiary Date signed 5-8-47

VS 188

correct age is especially important. Physicians: please write the

51642

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

G51642

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1471 Cookesie St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1471 Cookesie St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Statka

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 9 1877

8. AGE: Years 69 | Months 5 | Days 2 | If less than one day hr. min.

9. Birthplace Hungary (Town, county, and state)

10. Usual Occupation
11. Industry or business House wife

FATHER
12. Name Tobias Shank
13. Birthplace Hungary

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs Marie L. Caffee
(b) Address 1419 Cookesie St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/14/47 (month) (day) (year)

(c) Cemetery or crematory Holy Cross Cem
Location Arbutus Md.

18 (a) Funeral director Thomas J Thomas
(b) Address 16 Light St

19 MAY 13 1947 (Date rec'd by registrar) (b) Huntington Hillsboro, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-11 1947, at 11:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-9 1947 to 5-11 1947, and that I last saw h[illegible] alive on 5-11 1947.

	Duration
Immediate cause of death: Cerebral Hemorrhage	2 Days
Due to: Arteriosclerosis	1yr+
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. G. Fallod, M.D.
Address 207 Fort Ave. Date signed 5-12-47

VS 150

X

Every item of information should be carefully supplied. The word UNKNOWN, WITH UNDERSCORING, is to be used only when the information cannot be obtained. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G51643

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

Registered G51643

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3512 O'Donnell St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3512 O'Donnell St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian A. Behr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. WIDOWED

6 (b) Name of husband or wife George M. Behr

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/19/1890

8. AGE: Years 57 | Months 1 | Days 21 | If less than one day hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation Home Wife

11. Industry or business

FATHER
12. Name Carl O. Rock
13. Birthplace Germany

MOTHER
14. Maiden Name Mathilda Henning
15. Birthplace Germany

16 (a) Informant Otto Behr
(b) Address

17 (a) Burial (b) Date thereof 5/14/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lwarty's Cemt.
Location O'Donnell St.

18 (a) Funeral director Clarence F. Haffmann
(b) Address 1639 N. Broadway

19 (a) Filed by (b) Registrar

MAY 13 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1947, at 11 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from December 1943, to May 10 1947, and that I last saw her alive on May 10 1947.

Immediate cause of death Melano-sarcoma of face — Duration 7 months

Due to with generalized metastasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation November 1946
Major findings of operation: melanotic growth
of autopsy: None.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. A. Rosenblatt M. D.
Address 3078 O'Donnell St. Date signed 5-12-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G51644

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V/94a

Registered No. G51644

Please write or type information. Physicians: please correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1241 N. Curley St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town 1241 Curley St
(If outside city or town limits, write RURAL and give town)
(d) Street No. N
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Long

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Widowed

6 (b) Name of husband or wife Henry Long
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 2 - 1870

8. AGE: Years	Months	Days	If less than one day
76 77	8	9	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name M. Loudenschlager
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Anna Loudenschlager
15. Birthplace Balto. Md

16 (a) Informant Mrs M. Duffey
(b) Address 1241 N. Curley St

17 (a) Burial (b) Date thereof May 14-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location E. End North Ave.

18 (a) Funeral director Milton Schilling
(b) Address 394 Hanover St

19 (a) (Date received by registrar) (b) Huntington Hill, Md.

MAY 15 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11th 1947, at 9.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1945 to May 1947 and that I last saw him alive on April 1947.

Immediate cause of death Cardiac failure — Duration

Due to Coronary Thrombosis

Due to Pneumonia & Coronary Thrombosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas A. Brennan M. D.
Address 5217 Harford Rd Date signed 5-19-47

G51645

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G51645 Registered No.

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 928 E. BALTO. ST.
(c) Hospital or institution: 5

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 828 E. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT T. (BOB) STEVANS
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife ANNA
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) 1893.

8. AGE: Years 54 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation = RETIRED =
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant ANNA STEVANS
(b) Address 828. N. BALTO, ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 5-12-47 (month) (day) (year)
(c) Cemetery or crematory Westview Cemetery
Location Bloomsbury & Longwood Sts

18 (a) Funeral director Charles W. Fackenthal
(b) MAY 13 1947 Keyser St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 1947 at 9:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 8 1947 to May 9 1947 and that I last saw h.i.m alive on 8 of May 1947

Immediate cause of death Cerebral Hemorrhage (Apoplexy) - Recurrent — Duration 4 hrs.
Due to Hypertensive Cardio Vascular Disease. — 10 yrs
Due to
Other Conditions Hemoplegia — 3 yrs.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jos. Miller M. D.
Address 1615 E Baltimore St. Date signed 5-10-47

X

G51646

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 1312

Registered No. G51646

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 130 W. 24th street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 130 W. 24th street
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country —

3 (a) FULL NAME ELIZABETH WARNER

3 (b) If veteran, name war ——— | 3 (c) Social Security Account No. 217-16-3649

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: James B. Warner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 14, 1883

8. AGE: Years 64 | Months 1 | Days 27 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER: 12. Name ?
13. Birthplace

MOTHER: 14. Maiden Name ?
15. Birthplace

16 (a) Informant St. Vincent de Paul Confer
(b) Address 2801 N. Charles street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/14/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location

18 (a) Funeral director Guy J. Evans & Son Inc.
(b) Address 118 N. Mt. Royal Ave

19 (a) MAY 12 1947 (b) Baltimore, Md.
(Date received by Registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10, 1947, at 4 a M.

21. I certify that death occurred on the date above stated; that I attended deceased from June, 1947 to May 9, 1947 and that I last saw her alive on May 9, 1947

	Duration
Immediate cause of death: Coronary Thrombosis	Four hours.
Due to: Cardio-Vascular Disease.	3 years
Due to: Sclerosis.	1 year
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operations —
of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Wm. H. Rammelsberg M. D.
Address 2740 St. Paul St Date signed 5/13/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G51647

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 148a

Registered No. G51647

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd St. & Guilford Ave
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6524 Fait Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anna B. Potz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Otto Potz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1, 1872

8. AGE: Years 75 | Months 0 | Days 11 | If less than one day: hr. min.

9. Birthplace Czechoslavakia
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John Benda
13. Birthplace Czechoslavakia

MOTHER
14. Maiden Name Josephine Hrudenia
15. Birthplace Czechoslavakia

16 (a) Informant Hospital records
(b) Address 33rd St. & Guilford Ave.

17 (a) Burial (b) Date thereof 5/16/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Md

18 (a) Funeral director L. J. Regele
(b) Address 5395 Harford Rd.

19 (a) MAY 13 1947 (b) Huntingtown Williamsport, Md
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12, 1947, at 3:42 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 29, 1947 to May 12, 1947 and that I last saw her alive on May 12, 1947.

	Duration
Immediate cause of death: Generalized carcinomatosis	?
Due to: Carcinoma of the cervix uteri	?
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas. D. Chesser M. D.
Address Union Memorial Hosp. Date signed May 13, 1947

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G51648 Stevens
Harford & Hugo

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 46 B

Registered No. G51648

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1508 Cliftview Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1508 Cliftview Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert L. Ilgenfritz

3 (b) If veteran, name war — No
3 (c) Social Security Account No. 215-01-1671

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Margaret Ilgenfritz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 14, 1875

8. AGE: Years	Months	Days	If less than one day
71	5	28	hr. min.

9. Birthplace York, Pa.
(Town, county, and state)
10. Usual Occupation Painter
11. Industry or business Coreleanna Can Co

FATHER
12. Name Unknown
13. Birthplace Pa.

MOTHER
14. Maiden Name Sarah ?
15. Birthplace Pa.

16 (a) Informant Mr. John Joseph Ilgenfritz
(b) Address 1508 Cliftview Avenue

17 (a) Burial (b) Date thereof 5/16/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road.

19 (a) MAY 13 1947 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12th, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1947 to May 12 1947 and that I last saw h[illegible] alive on May 11 1947.

Immediate cause of death	Duration
Carcinoma Stomach	4 mo
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature L.F.A. Stevens M. D.
Address 2878 Harford Rd Date signed 5-12-47

V S 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

HEALTH DEPARTMENT—CITY OF BALTIMORE

G51649 CERTIFICATE OF DEATH ✓97 G51649

Registered No.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 409 Normandy Ave. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 50 yrs. mos. 1 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

If U. S. Veteran specify WAR

2. FULL NAME Lillie Basil

(a) Residence: No. 409 Normandy Ave. St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year) November 11, 1865

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	6	2	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Annapolis
(State or country) Md.

FATHER

13. NAME Nelson Basil

14. BIRTHPLACE (city or town) Annapolis
(State or country) Md.

MOTHER

15. MAIDEN NAME Margaret Dorsey

16. BIRTHPLACE (city or town) Annapolis
(State or country) Md.

17. INFORMANT Mrs. Margaret Mayo
(Address) 409 Normandy Ave.

18. BURIAL, CREMATION, OR REMOVAL
Place St. Ann's Cem. Date May 15 1947
Annapolis, Md.

19. UNDERTAKER E. Mallis Lamoreaux
(Address) 1003 W. Baltimore St.

20. FILED MAY 13 1947 19 Huntington Williams, Registrar.

OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) May 13, 1947

22. I HEREBY CERTIFY, That I attended deceased from March, 1945, to May 13, 1947

I last saw alive on May 12, 1947. Death is said to have occurred on the date stated above, at 3-A.M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cardiac Failure	
Other contributory causes of importance: Advanced Arteriosclerosis	1945

Was an operation performed? No Date of

For what disease or injury? No

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) Geo. E. Wells M. D.

(Address) 4100 Edmondson Ave.

X 5/13/47

G51650
314059

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G51650
Registered No.

1206

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 2991 Yorkaway (If rural give location)
(e) Citizen of foreign country (Yes or No) If yes, name country

3 (a) FULL NAME James R. Hall
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bernice N. Hall (nee Hunt)
6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) 10-13-16

8. AGE: Years 30 | Months 6 | Days 29 | If less than one day ____ hr. ____ min.

9. Birthplace W. Va. (Town, county, and state)

10. Usual Occupation Drilling Engineer
11. Industry or business

FATHER
12. Name Hekron L. Hall
13. Birthplace W. Va.

MOTHER
14. Maiden Name Edna F. Margan
15. Birthplace W. Va.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Ship (Burial, cremation, or removal) (b) Date thereof 5/13/47 (month) (day) (year)
(c) Cemetery or Community Pinehill
(d) Location Parkersburg W. Va.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) MAY 3 1947 (Date received by registrar) (b) Huntington West Virginia

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-13-1947, at 8:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-23-1947 to 5-13-1947 and that I last saw him alive on 5-12-1947.

Immediate cause of death: Perforation of intestine — Duration:
Due to: Ulcerative Colitis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation 12 May 47
Major findings of operation: Soiling of peritoneal cavity
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard D. Brady M. D.
Address J. H. H. Date signed 12 May 47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G51651 Kelso B. Beaver G51651

BALTIMORE CITY HEALTH DEPARTMENT

B.# D78432 CERTIFICATE OF DEATH 157E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Madison & Linden Ave

(c) Hospital or institution: Maryland Gen Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Brkwood Dist. Wms's County

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Baby Kelso B. Beaver

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Newborn

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/10/47

8. AGE: Years	Months	Days	If less than one day
—	—	3	hr. min.

9. Birthplace Balto. Md

(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER

12. Name Kelso F. Beaver

13. Birthplace Lexington Park St Mary's Co.

MOTHER

14. Maiden Name Agnes M. Hall

15. Birthplace Lexington Park St Mary's Co

16 (a) Informant Mother of Infant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 14, 1947 (month) (day) (year)

(c) Cemetery Sacred Heart

Location Bensmond Md

18 (a) Funeral director W. L. Mattingly Sons

(b) Address Leonardtown Md.

19 (a) (Registrar) (b) Huntingtown Md

MAY 13 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/12/47 19 at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/9/47 19 to 5/12/47 19, and that I last saw h alive on 5/12/47 19.

Immediate cause of death Interstinal Injury

Due to

Due to Patent Ductus Arteriosus

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Patent Ductus Arteriosus

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Thomas C. Walsh M. D.

Address Md Gen Hosp Date signed 5/13/47

G51652

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

~~G51652~~

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 301 Calverton Rd
(c) Hospital or institution: Convent of the Good Shepherd
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 y 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 301 Calverton Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sister Mary Raphael Manning

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 16-1874

8. AGE: Years	Months	Days	If less than one day
72	8	27	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Sister of the
11. Industry or business Good Shepherd

FATHER
12. Name Timothy Manning
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Ellen Sullivan
15. Birthplace Ireland

16 (a) Informant Sister Mary of Perpetual Help
(b) Address 301 Calverton Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 14-1947 (month) (day) (year)
(c) Cemetery or crematory Our Cathedral
Location Baltimore Md.

18 (a) Funeral director George E. Colmar.
(b) Address 2101 Frederick Ave.

19 (a) MAY 13 1947 (Date received by registrar) Hamilton for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 May 1947, at 11:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946, to 12 May 1947, and that I last saw h[illegible] alive on 12 May 1947.

Immediate cause of death Uremia — ?
Chronic Myocarditis — ?
Acute myocardial failure
Due to arteriosclerotic cardiovascular disease. — ?
Due to
Other Conditions Non Specific infiltration both lungs, Cause undetermined — ?
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Joseph E. Muse Jr. M.D.
Address 3311 St. Paul St Date signed 5/12/47
Balto. 18. Md. X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51653

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 516

G51653 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2914 E. Balto St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2914 E. Balto St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louis Karageorge

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Dora Karageorge
6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) Sept 22, 1876

8. AGE: Years 71 | Months 72 | Days 15 12 20 | If less than one day: hr. min.

9. Birthplace Turkey (Town, county and state)

10. Usual Occupation Real Estate

11. Industry or business Retired

FATHER
12. Name Bill
13. Birthplace Turkey.

MOTHER
14. Maiden Name Garfala
15. Birthplace Turkey.

16 (a) Informant Tony Karageorge
(b) Address 2914 E. Balto St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 14 47 (month) (day) (year)

(c) Cemetery or crematory Greek Orthodox
Location Hendon Smith Road

18 (a) Funeral director S. Walter Gray
(b) Address 619 N. Bouldin St.

MAY 14 1947 (b) Huntingtown, Md.
(Date received by local registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12, 1947 at 6.35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 18 1946 to May 12 1947 and that I last saw him alive on May 11 1947.

Immediate cause of death	Duration
Metastasis to liver of Carcinoma of prostate	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles C. MacMunn M. D.
Address 2911 E Balto St Date signed May 13

51654 BC#B-11394 BALTIMORE CITY HEALTH DEPARTMENT G51654
CERTIFICATE OF DEATH 157E

Please write plainly with pencil or pen and give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution South Balto Genl Hosp DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1702 Patapsco St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Barbara Lee King

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 18 1944

8. AGE: Years 2 | Months 6 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Frank King
13. Birthplace Va

MOTHER 14. Maiden Name Evelyn Muller
15. Birthplace Baltimore Md

16 (a) Informant Evelyn King
(b) Address 1702 Patapsco St

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 5/15/47 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore Md

18 (a) Funeral director Gilbert & Sons
(b) Address 1214 St Paul St

(c) Date received by registrar MAY 14 1947 Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1947, at 1:40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Congenital Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G Kelbrick M.D. Medical Examiner.
Date signed May 13, 1947

51655

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G51655

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5314 St George Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5314 St George Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Carlisle Lane, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Myrtle V

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 30, 1890

8. AGE: Years 56 | Months 6 | Days 13 | If less than one day hr. min. 14

9. Birthplace Los Angeles Calif (Town, county, and State)

10. Usual Occupation Real Estate

11. Industry or business

FATHER — 12. Name Charles H Lane

13. Birthplace Penn York

MOTHER — 14. Maiden Name Emma Kuhl

15. Birthplace Baltimore Md

16 (a) Informant Myrtle Lane

(b) Address 5314 St George Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Lakewood

Location Lakewood Md

18 (a) Funeral director Hilborn & Hilborn

(b) Address 1219 St Paul St

MAY 14 1947 (Date received by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 May 1947, at 11:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11 May 1947 to 13 May 1947 and that I last saw him alive on 12 May 1947

Immediate cause of death: Cerebral Hemorrhage — Duration: 3 days

Due to: Hypertensive Cardio-Vascular Disease — 5 yrs.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. H. Kammer, Jr.

Address 501 Reridan Ave. Date signed 13 May 47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

51656

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 63B

G51656 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2632 E. Monument St.
(c) Hospital or institution: Home
(d) Length of stay in hospital or instt. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 2632 E. Monument St. (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mannie L. Cassady

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife George W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7, 1894

8. AGE: Years	Months	Days	If less than one day
53	-	4	hr. min.

9. Birthplace Frederick, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER: 12. Name Charles E. Danner
13. Birthplace Md.

MOTHER: 14. Maiden Name Katherine Wills
15. Birthplace Md.

16 (a) Informant Robert E. Pine, Jr.
(b) Address 1818 Barclay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 14-47 (month) (day) (year)
(c) Cemetery or crematory Cemetery Bolt
Location Baltimore
18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul St.

19 (a) Date received MAY 14 1947 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 May 1947 at 11 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12 Nov 1946 to 11 May 1947 and that I last saw him alive on 10 May 1947

Immediate cause of death: Coronary Occlusion — Duration: appx 6 mos
Due to
Due to
Other Conditions: Hypostatic Pneumonia
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Howard F. Goodman, M.D.
Address 1515 N. Milton Ave Date signed 14 May 1947

94a

551657

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1063

Registered No. C51657

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Worcester
(c) City or town Neck Church
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Blanche Ann Burn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, (Married) widowed, or divorced.

6 (b) Name of husband or wife Clarence Burn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/24 1906

8. AGE: Years 41 | Months 2 | Days 14 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business At home

FATHER
12. Name James Reid
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Taylor
15. Birthplace Md.

16 (a) Informant Hospital records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 15 1947 (month) (day) (year)
(c) Cemetery or crematory Ramsay Camp
Location Pocomoke Md

18 (a) Funeral director Dennis Watson
(b) Address Pocomoke Md

19 (a) MAY 14 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/12 1947 at 1 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/21 1947 to 5/12 1947 that I last saw h.w alive on 5/12 1947

Immediate cause of death: Pulmonary Embolus — Duration:
Due to: Ruf - Of. Pneumonectomy
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Blackenburgh Jones M. D.
Address The University Hosp. Date signed 5/14/47

VS 150

every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

51658

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1131a

Registered No. C51658

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 454 Minnesota Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 W
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4571 Minnesota ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry A Smith

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Mary E Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 9 187[illegible]

8. AGE: Years	Months	Days	If less than one day
76	6		hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Potter
11. Industry or business

FATHER
12. Name Geo Smith
13. Birthplace Md

MOTHER
14. Maiden Name Dont Know
15. Birthplace Md

16 (a) Informant Mrs Anna E Mason
(b) Address 4571 Minnesota Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 14 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) MAY 14 1947 (Date received by Registrar) (b) Huntington Williams MD

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11th 1947; at 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 12 1947 to May 11 1947 and that I last saw h[illegible] alive on May 11 1947

Immediate cause of death: Cerebral Hemorrhage
Due to: Chronic Myocarditis
Due to: Chronic Nephritis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration Between Onset and Death

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dwight L Snyder MD
Address 3373 E Balto Date signed May 13 1947

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

51659

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G51659 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Days.
(e) Length of stay in Baltimore (yrs., mos., or days) 82 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter de Shields

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife Catherine Freehart

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15, 1865

8. AGE: Years 82 | Months 12 | Days 29 | If less than one day hr. min.

9. Birthplace Howard County Md.
(Town, county and state)

10. Usual Occupation Butcher

11. Industry or business

FATHER
12. Name Nicholas de Shields
13. Birthplace Maryland

MOTHER
14. Maiden Name Alice Brophy
15. Birthplace Maryland

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley Street. city

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 16, 1947 (month) (day) (year)
(c) Cemetery or crematory St. Mary's Hampden
Location Baltimore

18 (a) Funeral director Rita Wredefeld
(b) Address 900 East Biddle St.

MAY 14 1947 (Date received by local registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 - 1947, at 2.25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 - 1947, to May-13 1947 and that I last saw him alive on May 12 - 1947.

Immediate cause of death	Duration
Edema Lungs	2 days
Due to Chronic myocarditis	5 yrs
Due to	
Other Conditions Arterio-Sclerosis	10 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E. North ave Date signed May 15/47

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Special care is especially important.

G51660

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G51660 Registered No.

PLEASE REPORT ALL ITEMS. Every item of information should be carefully supplied. TYPEWRITING OR INDELIBLE PENCIL. WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Special attention is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 909 S. Decker Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 62yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 909 S. Decker Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3.(a) FULL NAME Thomas J. Donohue

3 (b) If veteran, name war ---
3 (c) Social Security Account No. ----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife May Donohue
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 24, 1878

8. AGE: Years	Months	Days	If less than one day
68	4	19	hr. min.

9. Birthplace England (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER 12. Name Thomas T. Donohue
13. Birthplace Ireland

MOTHER 14. Maiden Name Margaret McAndrew's
15. Birthplace Ireland

16 (a) Informant Raymond Donohue Brooklyn
(b) Address 199 Jefferson St. N.Y.6

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 16/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md.

18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Orleans St.

MAY 14 1947 Filed Washington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12, 1947 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 16 1946 to May 12 1947
and that I last saw him alive on May 11 1947

Immediate cause of death: Hypertensive Arteriosclerotic C.V. Disease — Duration 6-16-46

Due to: Acute Coronary Occlusion — Duration 5-12-47

Due to — Duration

Other Conditions None

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. A. Schemmerhorn M. D.
Address 542 S. East Ave. Date signed 5-14-47

X

G51661

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 186a

Registered No. G51661

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dod.
(e) Length of stay in Baltimore (yrs., mos., or days) 10

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town New York (If outside city or town limits, write RURAL and give town)
(d) Street No. 25 South Street (If rural give location)
(e) Citizen of foreign country? YES (Yes or No)
If yes, name country FINLAND

3 (a) FULL NAME ANDERS F. NUMMELIN

3 (b) If veteran, name war: NONE
3 (c) Social Security Account No.: NONE

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: UNKNOWN

6 (b) Name of husband or wife: UNKNOWN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT-16-1896

8. AGE: Years 50 | Months 7 | Days 19 | If less than one day ..... hr. ..... min.

9. Birthplace FINLAND (Town, county, and state)
10. Usual Occupation SEAMAN
11. Industry or business

FATHER
12. Name
13. Birthplace UNKNOWN

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace

16 (a) Informant WILLIAM MATTIN
(b) Address 2144 YORK AVE. N.W. WASHINGTON. D.C.

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof MAY 14 1947 (month) (day) (year)
(c) Cemetery or crematory GREEN MOUNT
Location GREEN MOUNT. AVE. BALTO. MD

18 (a) Funeral director H. SANDER & SON-INC.
(b) Address 1649 E NORTH. AVE. BALTIMORE MD.
(c) Date MAY 14 1947 Filed Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5, 1947, at 9:45 P.M.

I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH: Fractured skull
Intracranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-5-47 about 7 a. 2/3 M.
(b) Where did injury occur? 1639 Thames St. Baltimore, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Fell in yard.

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 5/5/47

VS 151

Correct age at approximate time of death. Physicians: please write the causes of death clearly and legibly.

51662

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

G51662 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5120 Ardmore Way
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5120 Ardmore Way
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME May Elizabeth Warner

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex: F.

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Harry

6 (c) If alive, give age 83 years

7. Birth date of deceased (mo., day, yr.) May 12, 1881

8. AGE: Years 65 | Months 11 | Days 29 | If less than one day hr. min.

9. Birthplace Balto. (Town, county and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Thomas J. Price
13. Birthplace Balto.

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace Balto.

16 (a) Informant Charles P. Covington
(b) Address 5120 Ardmore Way

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 5/14/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Frederick Rd.

18 (a) Funeral director M. W. E. Dippel's Sons
(b) Address 7110 Belair Rd.
(c) MAY 14 1947 (Date rec'd by registrar) (d) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1947, at 3:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1946 to 5/11 1947 and that I last saw h[illegible] alive on 5/10 1947.

Immediate cause of death: Carcinoma Rectum — Duration: 6 Years
Due to: ✓
Due to: ✓
Other Conditions: ✓
(Include pregnancy within 3 months of death)
Date of operation: ✓
Major findings of operation: ✓
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Harding
Address 4810 Belair Rd. Date signed 5/13/47

V S 150

Every item of information should be carefully supplied. Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G51663

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 93c

G51663
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 7

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Fallston
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Marie Ayers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race White

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Wm R Ayres

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 28 - 1913

8. AGE: Years 34 | Months 1 | Days 15 | (If less than one day hr. min.)

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Home wife

11. Industry or business

FATHER
12. Name George F Neuner
13. Birthplace Baltimore

MOTHER
14. Maiden Name Marguerite Sink
15. Birthplace Baltimore

16 (a) Informant Wm R Ayres
(b) Address Fallston md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 17 47 (month) (day) (year)
(c) Cemetery or crematory Highland
Location Street, Md

18 (a) Funeral director Charles E. Kurtz
(b) Address Jarrettsville Md

19 (a) Date received MAY 14 1947 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-13 1947, at 5:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-11 1947 to 5-13 1947. and that I last saw h[illegible] alive on 5-13 1947.

Immediate cause of death	Duration
Acute failure	
Due to Acute Dilatation Heart	
Due to Rheumatic CVD	
Other Conditions Bronch. infl. at base	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harvey Gurley M. D.
Address Univ. Hosp. Date signed 5-13

VS 150

If any item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51664 G51664

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the cause to which death should be charged statistically.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1214 Eutaw Place
(c) Hospital or institution: Balto Eye + Ear Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 3 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1611 Ellamont St
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Louisa H. Callender

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Mr. David Callender Jr.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 17, 1865

8. AGE: Years 81 | Months 4 | Days 25 | If less than one day 2/6 hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business —

FATHER
12. Name Clifford C. Anderson
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary A. Cannon
15. Birthplace Mississippi (Natchez)

16 (a) Informant Sister Miss E Alexander
(b) Address 1611 Ellamont ST

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 5/14/47 (month) (day) (year)
(c) Cemetery or crematory Blandford Cem.
Location Petersburg, Va.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAY 14 1947 (Date received by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1947, at 12 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 3 1947, to May 12 1947, and that I last saw h.. alive on May 12 1947.

Immediate cause of death Cardiac failure
under General (Spinal) Duration
Anesthesia

Due to

Due to

Other Conditions Arteriosclerosis
Senile Cataract left Eye
(Include pregnancy within 3 months of death)

Date of operation May 13, 1947

Major findings of operation: Cataract extraction

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 11 +
(a) Accident, suicide, or homicide Accident.
(b) Date of occurrence 5/12/47 12 P M
(c) Where did injury occur? Balto Eye & Ear Hospital
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public While at work?
(Specify type of place)
(e) Means of injury Operating table - Anesthesia
23. Signature Jos. S. Friedenwald
Address 1212 Eutaw Pl. Balto Date signed 5/17/47

VS 3 For the office of the Medical Examiner

X

51665

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G51665 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3400 Walbrook Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3400 Walbrook Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM P. BIGELOW

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Georgia S. Bigelow
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15, 1866

8. AGE: Years 81 | Months 0 | Days 27 | If less than one day: hr. min.

9. Birthplace Annapolis, Md. (Town, county, and state)
10. Usual Occupation Recorder Emeritus
11. Industry or business Boumi Temple

FATHER
12. Name Waldo Bigelow
13. Birthplace Mass.

MOTHER
14. Maiden Name Mary Phillips
15. Birthplace Annapolis, Md.

16 (a) Informant Mr. George O. Bigelow
(b) Address 3400 Walbrook Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/15/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAY 14 1947 (Date rec'd by Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12, 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 4, 1947 to May 12, 1947 and that I last saw him alive on May 11, 1947.

Immediate cause of death: Coma. — Duration: 2 days
Due to: Shock & circulatory failure — 2 days
Due to: Fracture L. subtrochanteric femur — 10 days
Other Conditions: Arterio-Sclerosis and senility — ?
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 15/6
(a) Accident, suicide, or homicide accident
(b) Date of occurrence May 3, 1947 at M
(c) Where did injury occur? Baltimore City, Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? no
(e) Means of injury Slipped & fell on floor

23. Signature Maurice L. Abelson M. D.
Address 3320 N. Charles St. Date signed 5/13/47

Earl R. Rogers X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51666

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V-93D

G51666 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2009 Cecil Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2009 Cecil Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME KATHERINE GERTRUDE EDGECUMBE

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lawrence Elliott Edgecumbe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18, 1876

8. AGE: Years 70 | Months 11 | Days 24 | If less than one day 25 hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Thomas R. Wingrove
13. Birthplace Richmond, Va.

MOTHER
14. Maiden Name Mary E. Canby
15. Birthplace Balto., Md.

16 (a) Informant Mr. Laurence E. Edgecumbe
(b) Address 2009 Cecil Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/15/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAY 14 1947 Huntington Williams M.D.
(Date rec'd by Registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12, 1947, at 5:30a M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to May 1947, and that I last saw her alive on 11 May 1947

Immediate cause of death Heart failure — Duration 2 wks

Due to Arteriosclerotic hypertrophic cardio-vascular disease — 5 years

Due to — —

Other Conditions Cerebro-vascular accident — 2 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leo M Zimmerman M. D.
Address 2838 Harford Rd Date signed 13 May 47

X

PRINCIPAL FACTS, WITH UNDERLYING ETIOLOGY, AND CONTRIBUTORY CAUSES. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1667

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 94a

Registered No. G51667

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2223 Poplar Grove St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2223 Poplar Grove St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET GERALDINE TRACEY (nee Schneider)

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Wm. S. Tracey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 13, 1892

8. AGE: Years 54 | Months 9 | Days 29 | If less than one day hr. min.

9. Birthplace Haverstraw, N. Y. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Matthew Schneider
13. Birthplace Germany

MOTHER
14. Maiden Name Isabelle MacCauley
15. Birthplace N. Y.

16 (a) Informant Mr. Wm. S. Tracey
(b) Address 2223 Poplar Grove St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/14/47 (month) (day) (year)
(c) Cemetery or crematory Pine Grove U. B.
Location Balto. Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAY 14 1947 (Date received by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12, 1947 at 4:25 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1947 to May 12 1947
and that I last saw h alive on May 12 1947

	Duration
Immediate cause of death: Coronary Thrombosis	1 day
Due to: Coronary Thrombosis	6 mos
myocardial infarct	6 mos
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Daniel R. Christ M. D.
Address 435 Eugaw St. Balto. MD Date signed 5/13/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. This

51668

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G51668 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 HARFORD AVE.
(c) Hospital or institution:
CONVALESCENCE HOME.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3. DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) ~~LIFE~~ 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1107 WEST 37th STREET.
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME CATHERINE V. PHELPS.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Harford Phelps

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 9-1865

8. AGE: Years 81 | Months 9 | Days 3 | If less than one day hr. min.

9. Birthplace Howard Co. Maryland (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Benjamin F. Peddicord
13. Birthplace Maryland

MOTHER 14. Maiden Name Margaret A. Dorsey
15. Birthplace Maryland

16 (a) Informant Mrs. Edith M. Linton
(b) Address 630 Colorado Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 16-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Marys Hampden
Location Baltimore, Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) Date received MAY 14 1947 (Registrar) Typewriting for Williams M.D. Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH MAY 12 1947. 19 , at 3.40 M

21. I certify that death occurred on the date above stated; that I attended deceased from MAY 11 1947 to MAY. 12 1947, and that I last saw h ER alive on MAY 12 19 47.

Immediate cause of death	Duration
CHRONIC MYOCARDITIS MARCH	1947.
Due to ARTERIOR SCLEROSIS	1946.
Due to CHRONIC ARTHRITIS.	1945.
Other Conditions SENILITY. (Include pregnancy within 3 months of death)	
Date of operation NONE	
Major findings of operation: NONE	
of autopsy: NONE	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas Oldactive M. D.
Address 3013 ST PAUL STREET Date signed MAY 13 1947.

VS 150

X

Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

651669

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registration No. 651669

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4308 Falls Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4308 Falls Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Henry L. Glantz

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-01-2242

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Gladys May Glantz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10-1911

8. AGE: Years 35 | Months 9 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Manager

11. Industry or business A & P Store

FATHER 12. Name Frederick Glantz

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden Name Anna F

MOTHER 15. Birthplace Maryland

16 (a) Informant Mrs. Gladys M. Glantz

(b) Address 4308 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 14-1947 (month) (day) (year)

(c) Cemetery or crematory Western

Location Baltimore, Md.

18 (a) Funeral director Burgee Funeral Home

(b) Address 3631 Falls Road

(Date received by registrar) MAY 14 1947 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1947, at 12:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1947 to May 12 1947, and that I last saw h[im] alive on May 11 1947

Immediate cause of death	Duration
Coronary Thrombosis	1 hour
Due to Angina Pectoris	
Due to Hypertensive CVD	2 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lawrence J. Linnane M. D.

Address 711 Fallsway Date signed 5-16-47

V S 150

X

G51670

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G51670

Write the causes of death clearly and legibly. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 913 Bayard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELIZABETH RAMOSKA

3 (b) If veteran, name war	3 (c) Social Security Account No.
V	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Frank
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace Lith. (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name George Salanski
13. Birthplace Lith.

MOTHER
14. Maiden Name ?
15. Birthplace Lith

16 (a) Informant Frank Ramoska
(b) Address 913 Bayard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 17-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Balair Rd

18 (a) Funeral director Joseph Kaunskas
(b) Address 640 Park Blvd.

MAY 14 1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1947, at 11 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary thrombosis
Myocardial infarction
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. (Medical Examiner.)
Date signed 5/13/47

VS 191

51671

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Ref. 51671

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2027 Bank St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2027 Bank St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Catherine Theresa Gough

3 (b) If veteran, name war —

3 (c) Social Security Account No. ?

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife ?

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 5-16-1871

8. AGE: Years 75 | Months 11 | Days 12 | If less than one day — hr. — min.

9. Birthplace Washington, D.C.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER
12. Name Michael Lyston
13. Birthplace Ireland

MOTHER
14. Maiden Name Isabella Rice
15. Birthplace Ireland

16 (a) Informant Mrs. Catherine McManus
(b) Address 2027 Bank St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-17-1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Avenue

18 (a) Funeral director Lilly & Zeiler Sons
(b) Address 403 S. Wolfe St.

19 (a) MAY 14 1947 (Date received by Registrar) (b) [illegible]

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12- 1947, at 11:50 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1- 1947 to May 12, 1947, and that I last saw h[illegible] alive on May 11 1947.

Immediate cause of death Cerebral Haemhorrage — Duration

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Aileen C. Smithers, M. D.

Address 3139 E. Baltimore St. Date signed May 14-47

X

G51672

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G51672

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 3709 Eastern Ave
(If outside city or town limits, write RURAL and give town)
(d) Street No. Balto - Md
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME McDarrell - John J - Dr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Nettie H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct-25-1882

8. AGE: Years 64 | Months 6 | Days 17 | If less than one day hr. min.

9. Birthplace Wheeling W. Va.
(Town, county, and state)

10. Usual Occupation Physician

11. Industry or business

FATHER
12. Name Andrew McDarrell
13. Birthplace Unknown

MOTHER
14. Maiden Name Sarah ?
15. Birthplace Unknown

16 (a) Informant John L. McDarrell
(b) Address 1732 15th Seattle, Wash.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/15/47 (month) (day) (year)

(c) Cemetery or crematory Baltimore
Location Eastern Ave & North Ave

18 (a) Funeral director Libby & Zeiler Co.
(b) Address 408 S. Wolfe St.

19 (a) MAY 14 1947 (Date rec'd by registrar) Washington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1947 at 5:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 2 1947 to May 12 1947 and that I last saw him alive on May 11th 1947

Immediate cause of death Respiratory failure.

Due to Cerebral Hemorrhage.

Due to Hypertension.

Other Conditions Arteriosclerosis.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James Alexander Jr. M. D.

Address Bon Secours Hospital Date signed 5/12/47

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

51673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54a

G51673 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 dys.
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1540 N. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Steen, Edwin P. (EDWIN PENTZ STEEN)

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 212-09-9098

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Clare Steen

6 (c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.) 11-29-97

8. AGE: Years 49 | Months 5 | Days 12 | If less than one day — hr. — min.

9. Birthplace Maryland
(town, county and state)

10. Usual Occupation Shipyard Worker

11. Industry or business Coast Guard Curtis Bay

FATHER
12. Name Hiram Steen
13. Birthplace Maryland

MOTHER
14. Maiden Name Edith Eccleston
15. Birthplace Maryland

16. Informant: Records JOHNS HOPKINS HOSPITAL
Address

17 (a) Burial (b) Date thereof 5/14/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) MAY 14 1947 (b) Huntington Williams M.D.
Date received by registrar Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-11-1947, at 10:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-8 1947 to 5-11 1947, and that I last saw h[illegible] alive on 5-11- 1947.

Immediate cause of death	Duration
Post-operative hypothermia	
Due to Partial removal	
contracranial neoplasm.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 5-10-47

Major findings of operation: Third ventricular Glioma

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles W. Burkland M. D.
Address Johns Hopkins Hospital Date signed 5-12-47

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. USE BLACK INK.

51674

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

G51674
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 339 Stricker St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James (Holland) Holley

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1914

8. AGE: Years	Months	Days	If less than one day
33			hr. min.

9. Birthplace N.C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace

MOTHER
14. Maiden Name Carrie Walker
15. Birthplace N.C.

16 (a) Informant Sarah Moore
(b) Address 307 N Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/15/47 (month) (day) (year)
(c) Cemetery or crematory
Location Norfolk Va.

18 (a) Funeral director Elroy A. Wilson
(b) Address 1000 Brantley Ave

MAY 14 1947 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/11 1947 at 7:30 A.M.

21. I certify that I took charge of the remains described above, held an Insp. or Inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CUSE OF DEATH Shock
Asphyxiation - Carbon Monoxide poisoning
Due to 2nd - 3rd degree Burns
Severe extensive - Left arm

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5/11/47 at 12:45 A.M. 19/1
(b) Where did injury occur? 339 Stricker St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? NW
(d) Means of injury Smoking in bed - Clothes ignited.

23. Signature Earl L. Key M.D.
Medical Examiner.
Date signed 5-12-47

VS 191

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51675

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G51675
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Linden & Madison Sts
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Rodgers Forge
(If outside city or town limits, write RURAL and give town)
(d) Street No. 207 Hopkins Road #12
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** George Edward Case

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed or divorced: married

6 (b) Name of husband or wife: Dorothy C. Case
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Dec 31 1904

8. AGE: Years 42 | Months 4 | Days 13 | If less than one day: ____ hr. ____ min.

9. Birthplace: Balto. Md.
(Town, county, and state)

10. Usual Occupation: Commodity Broker

11. Industry or business: Self employed

FATHER
12. Name: George E. Case
13. Birthplace: Troy Pa

MOTHER
14. Maiden Name: Minnie Hazard
15. Birthplace: New York State

16 (a) Informant: Mr. Duane Rice (Brother-in-law)
(b) Address: 3902 St Paul St Cty 18

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof May 16 47 (month) (day) (year)
(c) Cemetery or crematory: Gevans Memorial
Location: Baltimore

18 (a) Funeral director: STEWART & MOWEN COMPANY
(b) Address: (E. F. Mowen Asst.) 700 N. Howard Avenue

MAY 14 1947
(Date rec'd by Reg'r) (Signature) Huntington Williams M.D.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13th 1947, at 9.45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 12 1947, to May 13 1947, and that I last saw him alive on May 13 1947.

Immediate cause of death: Heart failure — Duration: 1 Day
Due to: Coronary occlusion
Due to:
Other Conditions: Hypostatic pneumonia
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: G E. Gonzalez M. D.
Address: Maryland General Hospital Date signed 5/13/47

X

G51676

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G51676

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Temple Garden Apts 403 City (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Theodore Goldstrom

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
m	w	married

6 (b) Name of husband or wife Mrs. Edyth Goldstrom
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1, 1892

8. AGE: Years	Months	Days	If less than one day
54	10	12	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business Chesapeake Steel Mfg.
FATHER 12. Name Herman Goldstrom
13. Birthplace Baltimore Md
MOTHER 14. Maiden Name Emma Peyser
15. Birthplace Baltimore, Md.
16 (a) Informant Mrs. Edyth Goldstrom
(b) Address Temple Garden Apts 403 City
17 (a) Accurate (Burial, cremation, or removal) (b) Date thereof 5-15-47 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Balto. Hebrew
Location Balto. Md.
18 (a) Funeral director Harris Sonnheim Son
(b) Address 902 Eutaw Place
19 (a) ~~May 14 1947~~ (b) ~~Huntington Williams, M.D.~~

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1947, at 4:09 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 3 1947 to May 13 1947 and that I last saw him alive on May 12 1947

Immediate cause of death: Uraemia — Duration: 2 wks
Due to: Hypertensive cardio vascular disease — 7 yrs
Due to: (malignant) Chronic glomerular nephritis
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: No autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Crawford N. Kilpatrick Jr. M. D.
Address Union Memorial Hosp. Date signed 5-13-47

VS 150

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

51677

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered No. G51677

Every item of information should be carefully supplied. Write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2339 Eutaw Place (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME MILTON H. FRANK (Milton H. Frank)
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug (abt 1876)
8. AGE: Years about 70 Months 9 Days If less than one day hr. min.
9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Retired ?
11. Industry or business
FATHER 12. Name Moses Frank,
13. Birthplace Balto. Md.
MOTHER 14. Maiden Name Carrie Rosenstock,
15. Birthplace Germany.
16 (a) Informant Mr. Thos. P. Sparagus
(b) Address 120 N. Liberty St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/14/47 (month) (day) (year)
(c) Cemetery or crematory Balto. Hebrew
Location Balto. Md.
18 (a) Funeral director Harris Funeralizing Co.
(b) Address 1202 Eutaw Place
MAY 14 1947 (a) Date received by Registrar (b) Registrar for Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 13 1947, at 6:00 AM
21. I certify that death occurred on the date above stated; that I attended deceased from 6-27 1946, to 5-13 1947, and that I last saw HIM alive on MAY 13 1947
Immediate cause of death CARCINOMA OF THE BLADDER WITH METASTASES — Duration
Due to [redacted]
Due to
Other Conditions POLYCYSTIC RENAL DISEASE
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: AS ABOVE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Samuel Lerman M. D.
Address Sinai Hosp. Date signed

V S 150

G51678

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1943

Registered No. G51678

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W Va (b) County
(c) City or town Piedmont
(If outside city or town limits, write RURAL and give town)
(d) Street No. 11 Dundee St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Edward Snakenberg

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-19-92

8. AGE: Years 54 | Months 4 | Days 25 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Telegraph operator

11. Industry or business

FATHER
12. Name James W. Snakenberg
13. Birthplace W Va.

MOTHER
14. Maiden Name Saldie Miller
15. Birthplace Md.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 15 1947 (month) (day) (year)
(c) Cemetery or crematory
Location Pikesville Md.

18 (a) Funeral director John E. Moran
(b) Address 3600 E Baltimore

MAY 14 1947
(a) Date rec'd by Registrar (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1947 at 11:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 12 1947 to May 13 1947 and that I last saw him alive on May 13 1947.

Immediate cause of death	Duration
Air Embolism	
Due to Spinal air injection	5 minutes
Due to	
Other Conditions Anteriorplasmic	

(Include pregnancy within 3 months of death)

Date of operation 5-13-47
Major findings of operation: None
of autopsy: Air Embolism

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 5-13-47 at 11 P.M.
(c) Where did injury occur? J.H.H. Balto. Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public While at work? No
(Specify type of place)
(e) Means of injury Operating table-spinal inj.
23. Signature Arthur B. King
Address Johns Hopkins Hosp. Date signed 5/13/47

For C.C. Lehmann by Hunter D. Williams, M.D. X

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Where there are blanks, write UNKNOWN. Do not abbreviate. Be sure correct age is especially important.

G51679

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G51679 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd St. & Guilford Ave.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 33
(e) Length of stay in Baltimore (yrs., mos., or days) 57

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5000 Loss Road
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Reinhardt Zickl

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Edward J. Zickl
6 (c) If alive, give age? years

7. Birth date of deceased (mo., day, yr.) June 2, 1899

8. AGE: Years	Months	Days	If less than one day
57	11	11	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Reinhardt
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Dittus
15. Birthplace Maryland

16 (a) Informant Forgetti Funeral
(b) Address

17 (a) Burial (b) Date thereof 5/17/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director L. J. Kuck
(b) Address 5305 Harford Rd.

19 (a) MAY 14 1947 (b) Signature of registrar [illegible]
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13, 1947, at 2:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 10, 1947, to May 13, 1947, and that I last saw h[illegible] alive on May 13, 1947.

Immediate cause of death	Duration
Cerebral embolus	16 hrs.
Due to Ingrafted mitral valve	7
Due to Coronary occlusion	6 days
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of AUTOPSY: NO SIGNIFICANT GROSS PATHOLOGICAL FINDINGS — of autopsy NO EVIDENCE OF M/O. INFARCTION.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ernest V. deMoss M. D.
Address Union Mem. Hosp. Date signed 5-13-47

G51680 ✓ G51680

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver Sts
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1120 E. 30th Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Joseph F. Eberle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20 - 1889

8. AGE: Years	Months	Days	If less than one day: hr.	min.
57	9	22		

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation unemployed

11. Industry or business

FATHER 12. Name Dominic J. Eberle

13. Birthplace Bavaria

MOTHER 14. Maiden Name Ella Baxter

15. Birthplace N.Y.

16 (a) Informant Mrs. Mary C. Geckle

(b) Address 1120 E. 30th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/16/47 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Md

18 (a) Funeral director L. Keyser

(b) Address 5305 Harford Rd

19 (a) (Date received by registrar) MAY 19 1947 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1947, at 9 3/4 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 9 1947 to May 12 1947.
and that I last saw h[illegible] alive on May 12 47

Immediate cause of death: Cardio-respiratory failure — Duration

Due to Subdural Hemorrhage

Due to Fracture of Skull

Other Conditions Fracture of left Clavicle
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: Autopsy

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 9/4
(a) Accident, suicide, or homicide accident
(b) Date of occurrence May 9 1947 at 7 M
(c) Where did injury occur? 1601 E. 27th St (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fell down stairs.

23. Signature [illegible]

Address St. Joseph Hosp. Date signed 5/12/47

Hamlet J. Mercer, M.D. X

VS 150

G51681

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163 H

G51681 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 510 N. Chapel Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA HEJNAL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widowed

6 (b) Name of husband or wife Frank Hejnal
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/28/1877

8. AGE: Years	Months	Days	If less than one day
70	2	12	hr. min.

9. Birthplace Czechoslovakia
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Kulhava
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Unknown
15. Birthplace Czechoslovakia

16 (a) Informant Mrs. Patricia Davis - daughter
(b) Address

17 (a) Burial (b) Date thereof 5/14/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or Crematory Oak Hill
Location Horner's Lane, Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) Date received MAY 14 1947 (b) Huntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12, 1947, at 9 a. M.

21. I certify that I took charge of the remains described above, held an insp. & inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Carbon Monoxide poisoning.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-12-47 at 6 a. M.
(b) Where did injury occur? 510 N. Chapel St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Gas burners on but unlit

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 5-12-47

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51682

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 118

G51682 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write. Your report is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Frederick
(c) City or town Mt. Airy
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CARRIE SEWELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17, 1928

8. AGE: Years	Months	Days	If less than one day
18	9	26	hr. min.

9. Birthplace Carroll Co.
(Town, county, and state)

10. Usual Occupation House Work

11. Industry or business

FATHER 12. Name John Sewell
13. Birthplace Frederick Co

MOTHER 14. Maiden Name Margie Taylor
15. Birthplace Carroll Co

16 (a) Informant John Sewell
(b) Address Mt Airy

17 (a) Burial (b) Date thereof May 16 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Friendship
Location Near Damascus Montgomery

18 (a) Funeral director H. M. Sanford
(b) Address Mt Airy

19 (a) 1947 (b) Huntington Williams, M.D.
(Filed by registrar) Registrar

VS 191

MEDICAL CERTIFICATION P

20. DATE OF DEATH May 13 1947, at 10:45 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Atherosclerosis

Due to Acute Gastritis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L Royer M.D.
Medical Examiner.
Date signed 5-14-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

751683

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G51683 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2106 Pressbury St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2106 Pressbury St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abraham Zwoonitz

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Sarah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Grocer

11. Industry or business

FATHER
12. Name Nachmuy
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Sarah Zwoonitz
(b) Address 2106 Pressbury St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-14-47 (month) (day) (year)

(c) Cemetery or crematory Netzro Young Israel
Location Windsor Mill Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 1409 E Balto St.

19 (a) (Date rec'd by registrar) Huntington Williams M.D. Registrar

MAY 14 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-14- 1947; at 1915 M

21. I certify that deceased occupied on the date above stated; that I attended deceased from April 1 1947 to May 14 1947 and that I last saw deceased alive on May 3 1947

Immediate cause of death: Coronary Thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis T. Lewis

Address 1846 W Lafayette Ave (Date signed) 5/14/47 M.D.

G51684

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G51684

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1639 Thames St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Vitally

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 27, 1886

8. AGE: Years	Months	Days	If less than one day
61 60	2 3	13	hr. min.

9. Birthplace Astoria
(Town, county, and state)

10. Usual Occupation Seaman

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Astoria

MOTHER
14. Maiden Name Unknown
15. Birthplace Astoria

16 (a) Informant Charles Readman
(b) Address 247 S. Ann Street

17 (a) Burial (b) Date thereof May 10 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Mathias
Location O'Donnell St.

18 (a) Funeral director Wendell Deppel
(b) Address 315 S. Highland Ave

(c) Date received MAY 14 1947 Thurlington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1947 at 12:35 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Chester J. Lubinski, M.D. M.D.
Medical Examiner.
Date signed 5-10-47

Thomas J. Mencin, M.D.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51685

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G51685 Registered No.

Every item of information should be carefully supplied. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1714 Westwood ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 25 years

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1714 Westwood ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME (Harriette) Hattie Brady
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife James Brady
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 12, 1883

8. AGE: Years	Months	Days	If less than one day
64	4	-	hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Robert M. Lee
13. Birthplace Va

MOTHER
14. Maiden Name Mariah ?
15. Birthplace Va

16. (a) Informant Marie Jones
(b) Address 1714 Westwood ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-15-47 (month) (day) (year)
(c) Cemetery or crematory arbutus
Location md

18 (a) Funeral director George E. Nelson
(b) Address 1303 Forestmann St

14 1947 (Date received by registrar) Washington-Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1947, at 4.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1946 to May 12 1947 and that I last saw h[illegible] alive on May 12 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	3 yrs
Due to	
Due to	
Other Conditions Diabetes	3 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm A. White M. D.
Address 515 Lafayette Date signed 5/14/47

VS 150

937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G51686 ✓ 30

G51686

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. o A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 537 Mosher St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Blanche' Dyson (Lucy)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years	Months	Days	If less than one day
59 58			hr. min.

9. Birthplace md
(Town, county, and state)

10. Usual Occupation domestic

11. Industry or business

FATHER 12. Name James E. Dyson

13. Birthplace md

MOTHER 14. Maiden Name Lucy Brown

15. Birthplace Md

16 (a) Informant Walter Dyson

(b) Address 1115 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/16/47 (Month) (day) (year)

(c) Cemetery or crematory St Peters

Location Md

18 (a) Funeral director Geo. E. Kelson

(b) Address 1303 Pressman St

19 (a) MAY 14 1947 (Date rec'd) (year) (b) Huntington Williams Md (Registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11, 1947, at 6:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Syphilitic aortitis
Myocardial degeneration
~~Due~~ Edema of brain

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George E. Merrell M.D.
Medical Examiner.

Date signed 5/12/47

X

G51687

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

G51687
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3535 Keswick Rd
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3535 Keswick rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kenneth Wintermute

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-01-1183

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary Hall Wintermute

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 22 1889

8. AGE: Years 57 | Months 4 | Days 20 | If less than one day 21 hr. min.

9. Birthplace Carroll Co Md (Town, county, and state)

10. Usual Occupation Rubber Worker

11. Industry or business

FATHER
12. Name Jacob Wintermute
13. Birthplace Md

MOTHER
14. Maiden Name Emma ?
15. Birthplace Md

16 (a) Informant Mrs Mary Wintermute
(b) Address 3535 Keswick rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-15-47 (month) (day) (year)
(c) Cemetery or crematory Pine Grove
Location Mt Olivet Md

18 (a) Funeral director Jos L Speyer Jr
(b) Address 1512 Hollins St

19 (a) (Date received by registrar) (b) Huntington Williams M.D.

MAY 14 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-12 1947, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 9 1947 to 5-12 1947, and that I last saw him alive on May 12 1947.

Immediate cause of death: Acute Pulmonary edema — Duration 1hr

Due to Arteriosclerotic CVD

Due to

Other Conditions Possible Hypostatic Pneumonia — 6 mos

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Huntington Williams M.D.

Address 3711 Falls Rd Date signed 5-14-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51688

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G51688

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2707 Southern Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2707 Southern Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Henss.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Rose Henss
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25 1866

8. AGE: Years	Months	Days	If less than one day
81	1	19	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Baker
11. Industry or business Retired

FATHER
12. Name Adam Henss
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Seitz
15. Birthplace Germany

16 (a) Informant Mrs Ella Hempfield
(b) Address 2707 Southern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 16 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Rural

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) [illegible] (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1937, at 7.50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1936 to 5/13 1937 and that I last saw him alive on 5/10 1937

Immediate cause of death Coronary Occlusion — Duration 1/2 hour

Due to —

Due to —

Other Conditions Chronic Myo-Carditis — 5 years

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? None (Specify type of place) While at work?
(e) Means of injury —

23. Signature L. L. Gourley M.D.

Address 5106 Harford Rd Date signed 5/14/37

V S 150

G51689

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G51689 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 918 W. University Pkwy. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: DOROTHY BOSLER SLOAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: John L. Sloan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 18, 1905

8. AGE: Years 42 | Months 1 | Days 25 | If less than one day hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Herman E. Bosler
13. Birthplace: Carlisle, Pa.

MOTHER
14. Maiden Name: Carolyn Dickey Dulaney
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mr. John L. Sloan
(b) Address: 918 W. University Pkwy.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/15/47 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) MAY 14 1947 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION 10

20. DATE OF DEATH May 13 1947, at 1:17 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1940, to May 13 1947 and that I last saw h[illegible] alive on May 10 1947.

Immediate cause of death: Coronary Thrombosis — Duration: Duration

Due to: Arterio-Sclerosis, Hypertension — Duration: Gradual

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: W. H. Hoody, M.D.

Address: 1403 Park Ave. Date signed: 5/16/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB-110424 G51690

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

G51690 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8days
(e) Length of stay in Baltimore (yrs., mos., or days) 12yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 422 N. Gilmore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Eunice Deane Harris

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 20- 1911

8. AGE: Years 35 | Months 8 | Days 23 | If less than one day ..... hr. ..... min.

9. Birthplace Ga.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Ned Alridge
13. Birthplace Ga.

MOTHER
14. Maiden Name Annie K. Toote(d)
15. Birthplace Ga.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof May 16.47 (month) (day) (year)
(c) Cemetery or crematory
Location Americus Ga

18 (a) Funeral director Isaac L. Brown-Son
(b) Address 1080 Montgomery Street

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

MAY 14 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1947, at 5.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-5- 1947, to 5-13 1947, and that I last saw her alive on 5-13- 1947

Immediate cause of death: Pulmonary Tuberculosis, Far Advanced — Duration: 4 mos. (?)
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Refused

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Hunt
Address Balt. City Hosp. Date signed 5-M. 13-D. 47

X

G51691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 F

G51691 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4501 White Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4501 White Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** George Z. Thomas

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No. 121-05-0365

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Christine M. Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/23/1895

8. AGE: Years	Months	Days	If less than one day
52	-	21	hr. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation Electrician

11. Industry or business Ship yard

FATHER
12. Name Clyde E. Thomas
13. Birthplace Pa.

MOTHER
14. Maiden Name Alice R. Zettle
15. Birthplace Pa.

16 (a) Informant Christine Thomas
(b) Address 4501 White Ave.

17 (a) Burial (b) Date thereof 5 16 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory State College
Location State College Pa.

18 (a) Funeral directors Lasuaken & Samuel Horn
(b) Address 7401 Belair Rd.

19 (a) (b)
(Date rec'd by registrar)

M.A. 1947 Huntington Millinery, Inc.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14th 1947, at 1:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/11 1947 to 5/14 1947 and that I last saw him alive on 5/14 1947.

Immediate cause of death	Duration
CANCER OF GALL BLADDER & Metastatic Cancer	1 YR (?)
Due to: of the Liver	3 mos +
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John W Machen M.D.
Address 6331 Belair Rd Date signed 5/14/47

G51692

BC# D78295

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G51692 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4712 Frederick Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Collins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-13-47

8. AGE: Years | Months | Days | If less than one day hr. 5 min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name James F. Collins Sr
13. Birthplace Md.

MOTHER
14. Maiden Name Kathleen McHenry
15. Birthplace Md

16 (a) Informant James F. Collins Sr
(b) Address 4717 Frederick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 15 47 (month) (day) (year)
(c) Cemetery or crematory Mount Cathedral
Location Baltimore Md.

18 (a) Funeral director H. B. Wehrmann & Son
(b) Address 1300 Eutaw Pl.

19 (a) (b) Huntington Williams M.D.
(Date received by registrar)

MAY 14 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1947 at 7:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-13 1947 to 5-13 1947 and that I last saw h.. alive on 5-13 1947

Immediate cause of death Aspiration Stillbirth

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. Clinton Smith Jr. M.D.
M. D.
Address St. Agnes Hosp. Date signed 5/13/47

X

CASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G51693 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1102 Battery Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1102 Battery Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Charles Sudbrook

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Rose Ella Adams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 20, 1865

8. AGE: Years 81 | Months 8 | Days 22 | If less than one day hr. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Henry
13. Birthplace: Germany

MOTHER
14. Maiden Name: Katherine Newhaus
15. Birthplace: Germany

16 (a) Informant: Family
(b) Address: 1102 Battery Ave.

17 (a) B (Burial, cremation, or removal) (b) Date thereof 5/15/47 (month) (day) (year)
(c) Cemetery or crematory: Cedar Hill
Location: Brooklyn, Md.

18 (a) Funeral director: James L. McCauley
(b) Address: 730 E. Fort Ave.

19 (a) MAY 14 1947 (Date registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1947 at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1946 to May 12 1947
and that I last saw him alive on May 12 1947.

Immediate cause of death: Cerebral Hemorrhage — Duration: 4 days
Due to: Arteriosclerosis
Due to:
Other Conditions: Senility, Hemiplegia Left
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Isaac Miller M. D.
Address: 1228 N. Charles St. Date signed: X 5/14/47

G51694

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V/186a

G51694 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Marine Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DEACEASED:
(a) ~~State~~ Country Russia (b) County
(c) City or town Leningrad
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LEV BELJAKOV

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1910

8. AGE: Years	Months	Days	If less than one day
37			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Hospital Records
(b) Address

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 5-14-47 (month) (day) (year)
(c) Cemetery or crematory Greenmount Crematory
Location Baltimore, Maryland

18 (a) Funeral director WILLIAM J. TICKNER & SONS
(b) Address North & Pennsylvania Avenues

19 (a) 14 1947 (Date received by registrar) Registrar

VS 191

MEDICAL CERTIFICATION

A

20. DATE OF DEATH May 13 1947, at 12:15 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fracture of skull

Due to

Other Conditions Rupture of Right Kidney
Rupture of liver
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 25 1/2
(a) Date of injury 5-13-47 at 11:40 P M.
(b) Where did injury occur? S.S.Askeld in Fairfield Drydock
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial Place While at work? No
(d) Means of injury Fell from ~~co~~ deck to drydock

23. Signature [signature] M.D.
Medical Examiner.
Date signed 5-13-47

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51695

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G51695 Registered No. 46E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 901 Aisquith Street
(c) Hospital or institution:
Convent of Notre Dame
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 11 Months

2. USUAL RESIDENCE OF DECEASED:
(a) State Cambridge (b) County Mass.
(c) City or town Cambridge
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sr.M.Orontia Weser

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb.3,1878

8. AGE: Years 69 Months 3 Days 5 If less than one day hr. min.

9. Birthplace Danburg Conn.
(Town, county, and state)

10. Usual Occupation Teacher

11. Industry or business Religious

FATHER
12. Name Ferdinand Weser
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Heflinger
15. Birthplace Germany

16 (a) Informant Sr.M.Stan.Kostka
(b) Address 901 Aisquith Street

17 (a) Burial (b) Date thereof May 16 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Notre Dame
Location Glen Arm

18 (a) Funeral director Geo.M.Fuhrman & Son
(b) Address 411 N Wolfe St

MAY 14 1947 (Date registered) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1947, at 10.20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1946 to May 13 1947 and that I last saw her alive on May 7 1947

Immediate cause of death: Inoperable Carcinoma — Duration

Due to: Sigmoid

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Aug 1946

Major findings of operation: Colostomy done

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address 110 E Fayette Date signed 5/14/47

G51696 — Grave #7 — #7 — 630 — G51696

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH: Found on Sidewalk
(a) Baltimore City, Maryland
(b) Street address In front 639 W. Mulberry
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 4 -

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. [illegible] (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Unknown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years 45 (?) | Months | Days | If less than one day ____hr. ____min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location PUBLIC CEMETERY MAY 13 1947

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) MAY 14 1947 (Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26th 1947, at 5-35 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Edema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Emil Rogers M.D. Medical Examiner

Date signed 4/26/47

Physicians: please write the causes of death clearly and legibly. Exact age is especially important.

G51697

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G51697 Registered No.

PLEASE WRITE PLAINLY, WITH UNPADING INK. Every item of information should be carefully supplied. The date of age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3818 Brooklyn Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie A. Lesson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife (Deceased) John T. Lesson
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 25 1893

8. AGE: Years	Months	Days	If less than one day
53	9	18	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation ~~Housekeeper~~ At Home
11. Industry or business

FATHER
12. Name Philip Trick
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Barna
15. Birthplace Maryland

16 (a) Informant Bernice Sunstrom (Daughter)
(b) Address 1521 Marshall St.

17 (a) Buried (b) Date thereof May 16, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem. Co.
Location Baltimore Md.

18 (a) Funeral director A. Howard Evans
(b) Address 1300 W. Lexington St. (30)
19. MAY 14 1947 Huntington Station, Md.
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13, 1947, at 7:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 1947 to May 13 1947 and that I last saw her alive on May 13 1947.

Immediate cause of death: Respiratory Failure — Duration

Due to Cerebral Hemorrhage

Due to Essential Hypertension

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. Stansfield M. D.
Address 1521 Light St. Date signed 5-20-47

VS 150

83a

G51698

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G51698
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2846 Lake ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2846 Lake ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie A. Bernstein

3 (b) If veteran, name war	3 (c) Social Security Account No.
✓	✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married.

6 (b) Name of husband or wife Isidor Bernstein
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Dec. 22- 1882

8. AGE: Years	Months	Days	If less than one day
64	4	20/21	hr. min.

9. Birthplace Massachusetts.
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business at Home

FATHER
12. Name Dennis Driscoll
13. Birthplace Mass.

MOTHER
14. Maiden Name Mary A. Smith
15. Birthplace Mass.

16 (a) Informant Isidor C. Bernstein (Husband)
(b) Address 2846 Lake Av

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof May 16, 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem.
Location A.I.Q. Co., Md.

18 (a) Funeral director A. Bouvard Evans
(b) Address 1400 S. Charles St (30)

19 (a) (Date) (b) Registrar Huntington Williams M.D.

MAY 18 1947
150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1947, at 2 20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 12 1945 to May 12 1947, and that I last saw h[er] alive on May 12 1947.

Immediate cause of death — Duration
Bronchopneumonia — 2d.
Diabetes Mellitus — 2 yrs
Due to Generalized Arteriosclerosis — 2 yrs
Due to Chronic Interstitial Nephritis — 2 yrs

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation none 1947
Major findings of operation: Appendix & Gall
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature I. F. D. Stevens. M. D.
Address 2878 Harford Rd Date signed 5-13-47

X

IMPORTANT, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51699
5 7 5120

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 157E

G51699
Registered No.

Every item of information should be carefully supplied. The cause of death clearly and legibly. Physicians: please write plainly, WITH UNFADING INK. Every item is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Talbot
(c) City or town Easton (If outside city or town limits, write RURAL and give town)
(d) Street No. 215 Locust St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Gannon

3 (b) If veteran, name war
3 (c) Social Security Account No.
4 Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 11-28-20
8. AGE: Years 26 Months 5 Days 15 If less than one day hr. min.
9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William Gannon
13. Birthplace Md

MOTHER
14. Maiden Name Nora Reynolds
15. Birthplace Md

16 (a) Informant JOHNS HOPKINS HOSPITAL Records.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 15 1947 (month) (day) (year)
(c) Cemetery or crematory Spring Hill
Location Easton, Md.

18 (a) Funeral director Klein Funeral Home
(b) Address Easton, Md.

MAY 13 1947
(a) (Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1947 at 11:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 11 1947 to May 13 1947, and that I last saw h alive on May 13 1947.

Immediate cause of death	Duration
Congenital Heart Disease	Life
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 5/12/47
Major findings of operation: Pulmonic stenosis
of autopsy Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry T. Bahnson
Address J.H.H. Date signed 5/13/47

Permit for Williams, M.D.

G51700

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G51700

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 S. Fulton Ave.
(c) Hospital or institution:
20

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1942 Hollins St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Mary A. Leister

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Kirk E. Leister

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1868

8. AGE: Years 78 | Months 7 | Days 21 | If less than one day hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Joseph Toennies
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Germany

16 (a) Informant: Mrs. George A. Leister
(b) Address: 600 S. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 16, 1947 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet Cemetery
Location: Baltimore, Md.

18 (a) Funeral director: Wells Lawrason
(b) Address: 1003 W. Baltimore St.

MAY 15 1947 Huntington Williams M.D.
(Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1947, at 11.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1947 to 5/15/1947, and that I last saw her alive on 5/13/1947

Immediate cause of death	Duration
(a) Acute Myocarditis	2 days
Due to (b) Bronchopneumonia	10 days
Due to (c) Uremia	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Walter J. Bowers
Address: 4012 Edmondson Ave. Date signed 5/16/47

150

X

G51701 B(#) D 78486

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 157E

Registered No. G51701

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Baltimore
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Patricia Rose Witkowski

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: F
5. Color or race: White
6 (a) Single, married, widowed, or divorced: —

6 (b) Name of husband or wife: —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6 May 1947

8. AGE: Years | Months | Days: 7 | If less than one day: hr. min.

9. Birthplace Baltimore, MD. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Thomas Theodore Witkowski
13. Birthplace Brooklyn, N.Y.

MOTHER
14. Maiden Name Frances Elizabeth Poveskin
15. Birthplace East Orange, N.J.

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-15-47 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Glenarm, Md.

18 (a) Funeral director George A. Farley
(b) Address Lutherville, Md.

19 MAY 15 1947 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 May 1947 at 8:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6 May 1947 to 13 May 1947 and that I last saw her alive on 13 May 1947.

Immediate cause of death	Duration
Congenital heart disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy Congenital heart disease

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Everett B. Chamberlain M. D.
Address Union Memorial Hospital Date signed 5/14/47

VS 150 MAY 15 1947

X

G51702 — 5170X — G51702

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1923

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 HARFORD AVE.
(c) Hospital or institution: CONVALESENCE HOME 13-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3MONTH
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3103 FALLS ROAD.
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA E SMITH.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Joseph E. Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15th 1855

8. AGE: Years 91 | Months 7 | Days 28 | If less than one day ... hr. ... min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John E. Horstman
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Harford Convalescent Home
15. Birthplace 4700 Harford ave

16 (a) Informant Margaret Parrish
(b) Address Balto Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/16/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Balto. Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st

19 (a) ... (b) ...
(Date received by Registrar) Registrar

MAY 15 1947
VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH MAY 13 1947, 19... at 8.45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from APRIL 21 47 to MAY 13 19 47, and that I last saw her alive on MAY 13 19 47.

	Duration
Immediate cause of death: CHRONIC MYOCARDITIS APRIL 21	1947
ARTERIOR SCLEROSIS	1947
Due to: MITRAL REGURGITATION	1945
Due to:	
Other Conditions: SENILITY.	

(Include pregnancy within 3 months of death)

Date of operation: NONE

Major findings of operation: NONE

of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas O Hamilton M. D.
Address 3013 ST PAUL ST Date signed MAY 14 1947.

X

G51703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G51703

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct. are is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St Josephs Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 57yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 919 Harford Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John P. Wheeler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) 1/16/92

8. AGE: Years	Months	Days	If less than one day
54	3	27	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation None Retired

11. Industry or business Electrical

MOTHER / FATHER

12. Name John Henry Wheeler

13. Birthplace Md.

14. Maiden Name Laura Giles

15. Birthplace Md.

16 (a) Informant Harry Paisal

(b) Address 912 Harford Rd

17 (a) Burial (b) Date thereof 5/17/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory London Park

Location Balto. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 127 St. Paul St.

MAY 15 1947
(Date rec'd by registrar)

(b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 MAY 1947 at 11:32 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10 MAY 1947 to 13 MAY 1947 and that I last saw h. I M alive on 13 MAY 1947

Immediate cause of death CARDIO - Respiratory failure — Duration

Due to Abscess, left lung

Due to

Other Conditions Arteriosclerosis Lateral sclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Abscess left lung

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arthur J. Brian

Address St. Joseph's Date signed 5/14/47

VS 150

1147

G51704

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1246

5M-4 G51704 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 2-
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1736 - E. Lombard Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VIRGINIA NALLY - MaczKa

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed, or divorced:~~ Married

6 (b) Name of husband Anthony MaczKa

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15, 1916

8. AGE: Years 20 | Months 9 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name George Nally
13. Birthplace Md.

MOTHER
14. Maiden Name Evelyn (Unknown)
15. Birthplace Md

16 (a) Informant Anthony Maczka
(b) Address 1636 E Lombard St.

17 (a) Burial (b) Date thereof 5 16 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Cedar Hill
Location A. A. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 5 St. Paul St

MAY 15 1947

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14, 1947 at 12.40 a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fatty Degeneration of Liver

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl H. Reyer M.D.
Medical Examiner.
Date signed 5-14-47

VS 181

G51705

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 163H

5170 G51705
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 14-1
(c) Hospital or institution: Maryland General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1503 Park Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Gretch (Gretch. (O.M.)

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 218-10-5927

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Kathleen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 14 1880

8. AGE: Years	Months	Days	If less than one day
66	6	29	hr. min.

9. Birthplace Ohio (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Empire Nursery

FATHER
12. Name Sylvester Gretch
13. Birthplace Pa

MOTHER
14. Maiden Name Evelyn Hack
15. Birthplace Pa

16 (a) Informant Kathleen Gretch
(b) Address 1503 Park Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/16/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Oak Lawn
Location Eastern Ave. Extended

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 MAY 15 1947 (b) (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1947, at 5:00 P M

21. I certify that I took charge of the remains described above, held an Inqu. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation
Due to Illuminating gas
Other Conditions Despondency
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-13-47 at 5:30 P M.
(b) Where did injury occur? 1503 Park Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no.
(d) Means of injury Four burners on stove left unlit

23. Signature Chester J. Lubinski, M.D. M.D.
Medical Examiner.
Date signed 5-14-47

VS 181

Howard J. Mullins, M.D. X

#G51706

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G51706
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 31st & Wyman Park Dr.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo. 7days
(e) Length of stay in Baltimore (yrs., mos., or days) 1mo. 7days

2. USUAL RESIDENCE OF DECEASED:
(a) State District of Columbia (b) County Dist. Columbia
(c) City or town Washington
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2617 39th Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Wilmer Rinaca, Junior

3 (b) If veteran, name war: World War II
3 (c) Social Security Account No.: —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Adela Byer
6 (c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.) Nov. 8, 1907

8. AGE: Years	Months	Days	If less than one day
37	6	6	— hr. — min.

9. Birthplace Sparrows Point Maryland (Town, county, and state)
10. Usual Occupation U.S. Coast Guard Retired
11. Industry or business "

FATHER
12. Name Charles W. Rinaca
13. Birthplace Shenandoah, Va.

MOTHER
14. Maiden Name Hattie Boogher
15. Birthplace Elkton, Va.

16 (a) Informant: Patient
(b) Address As above

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 5/15/47 (month) (day) (year)
(c) Cemetery or crematory
Location Washington, D.C.

18 (a) Funeral director Wm. R. Humphreys
(b) Address Bethesda, Maryland

19 MAY 15 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1947, at 7:28 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1947 to May 14 1947 and that I last saw h. alive on May 14 1947

Immediate cause of death: Reach in - sufficiency — Duration 6 mo.
Due to: Reticulum Cell Sarcoma, generalized — 1 yr. 6 mo.
Due to —
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 4/23/47
Major findings of operation: Reticulum Cell Sarcoma
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Emory S. Ware M.D.
Address Women's Hosp. Date signed 5/15/47

X

G51707 IN. BOH # 78186 BALTIMORE CITY HEALTH DEPARTMENT Registered No. G51707
110485 CERTIFICATE OF DEATH 1579

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3- days
(e) Length of stay in Baltimore (yrs., mos., or days) 3- days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 215 S. Durham St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Rondon (Irene)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7th 1947

8. AGE: Years | Months | Days: 3 days | If less than one day: hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Leo Rondon
13. Birthplace Puerto Rica

MOTHER 14. Maiden Name Irene Sumler
15. Birthplace N. C.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) Cremated, cremation, [redacted] (b) Date thereof May 18th/47 (month) (day) (year)
(c) [redacted] crematory Baltimore City Hospitals
Location 4940 Eastern Ave (Records)

18 (a) Funeral director
(b) Address

19 (a) MAY 15 1947 (Date rec'd by registrar) (b) Thurlington Williams, Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10th 1947 19 , at 3.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 7th 19 47 , to May 10th 1947 , and that I last saw her alive on May 10th 19 47 .

	Duration
Immediate cause of death: Cardiac Failure	1 Day
Due to: Intestinal Obstruction	3 Days
Due to:	
Other Conditions: Toxemia Chr. Kidney Left (Include pregnancy within 3 months of death)	3 days.

Date of operation
Major findings of operation: Intestinal Malrotation
of autopsy: Toxemia, Nephritis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Julian J. Griffin M. D.
Address Balt. City Hosps. Date signed 12 May 1947

VS 150

G51708 Colt D-78168 CM. 110404

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

Registered No. G51708

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 219 W. Hannrietta St. 30
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nicholson Baby Boy-Twin-B Elizabeth

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4-1947

8. AGE: Years	Months	Days	If less than one day
0	0	1	hr. min.

9. Birthplace MD.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles Nicholson
13. Birthplace MC.

MOTHER
14. Maiden Name Elizabeth Morrow
15. Birthplace N.C.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Cremated (b) Date thereof May 12/1947
cremation, (month) (day) (year)
(c) crematory Baltimore City Hospital
Location 4940 Eastern Ave (Records)

18 (a) Funeral director
(b) Address

19 (a) MAY 15 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5- 1947, at 4.12 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 4 - 1947, to May 5 - 1947, and that I last saw him alive on May 5 - 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day
Due to Prematurity	1 day
Due to	
Other Conditions Atelectasis ?	1 day

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation Central Hemorrhage. Prolapsed Prematurity
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Julian P. Griffin M. D.
Address Balt. City Hosps. Date signed 10 May 1947

VS 150

G51709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 131a

Registered No. G51709

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3851 Roland Ave.
(c) Hospital or institution:
13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3851 Roland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Morrison.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow.

6 (b) Name of husband or wife Wilbur S.Morrison
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 8,1881

8. AGE: Years	Months	Days	If less than one day
66	4	4	hr. min.

9. Birthplace Virginia. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Stump.
13. Birthplace Va.

MOTHER
14. Maiden Name Belle Allison.
15. Birthplace Va.

16 (a) Informant LeRoy W.Morrison.
(b) Address 3851 Roland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 15/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave.

18 (a) Funeral director Chenoweth & Donovan.
(b) Address 17 Cheatnut Ave.

MAY 16 1947

19 (a) (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH May 12, 1947, at 7.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1947 to May 12 1947.
and that I last saw h[illegible] alive on May 12 1947.

Immediate cause of death [illegible] Duration
[illegible] 10 yrs
Due to
Due to
Other Conditions Arteriosclerosis, Bilateral Pneumonia. 3 days
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [illegible]
Address 3939 Reisterstown Rd. Date signed 5/14/47

G51710

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 307

Registered No. G51710

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3555 Fountain Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Walter Hood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Margaret H. Hood

6 (c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) June 2 1893

8. AGE: Years 53 | Months 11 | Days 10 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name Charles E. Hood
13. Birthplace Md.

MOTHER
14. Maiden Name Frances E. Holt
15. Birthplace Md.

16 (a) Informant Margaret H. Hood
(b) Address 3555 Fountain Ave

17 (a) Burial (b) Date thereof May 15/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location

18 (a) Funeral director Ehrenwerth & Donovan
(b) Address 3615-17 Chestnut Ave.

19 MAY 15 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12, 1947 at 12 05 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions Generalized arteriosclerosis and acute pneumonia
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D.
Medical Examiner
Date signed 5-12-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 191

94a

G51711

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93a

Registered No. G51711

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2202 Druid Hill Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2202 Druid Hill Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie R. Saunders

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8, 1885

8. AGE: Years	Months	Days	If less than one day
62	-	5	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Jake Clark
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Md.

16 (a) Informant Mr. Everett Saunders
(b) Address 407 Robert St.

17 (a) Burial (b) Date thereof 5-16-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (c) MAY 15 1947 Washington Williams
(Date rec'd by registrar)

MEDICAL CERTIFICATION P

20. DATE OF DEATH May 13, 1947 at 4:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-8 1947 to 5-13 1947 and that I last saw h[illegible] alive on 5/13 1947.

Immediate cause of death Acute Myocardial Infarction — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. J. Hatcher
Address 1115 Pine St. Date signed 5/15/47

V S 150

X

G51712

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G51712

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D. H.
(c) Hospital or institution: West Balto General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 910 Rosedale St (If rural give location)
Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert E. May

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 213-10-5577

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Katherine M. May
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) April 16 1900

8. AGE: 47 years	Months	Days	If less than one day
	0	27	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Dairy employee
11. Industry or business Assistant Foreman

FATHER
12. Name George F May
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Unknown
15. Birthplace Baltimore Md

16 (a) Informant Katherine M May
(b) Address 910 Rosedale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/17/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location

18 (a) Funeral director Charles P Powell
(b) Address Edmondson Ave

19 MAY 15 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/13 1947 at 6:45 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. P. Smelser M.D. Medical Examiner.
Date signed 5/13/47

VS 151

G51713 Dr. Harbold

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G51713

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not abbreviate. Write the cause of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3025 Hamilton Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3025 Hamilton Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Estella V. Gray

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widoed

6 (b) Name of husband or wife Edward M. Gray
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31, 1878

8. AGE: Years	Months	Days	If less than one day
68	9	12	hr. min.

9. Birthplace Frederick CO. Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Thomas Jacobs
13. Birthplace ?

MOTHER
14. Maiden Name Mary V. Simpson
15 Birthplace ?

16 (a) Informant Mrs. Mabel G. Fehrer
(b) Address 3025 Hamilton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/15/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, ge 14

19 MAY 15 1947 (b) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12, 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 8 1947 to May 12 1947 and that I last saw her alive on May 12 1947

Immediate cause of death Coronary thrombosis — Duration 16 hours
Due to Chronic myocarditis
Due to Hypertension
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. V. Harbold
Address 4206 Harford Road Date signed 5/13/47

V S 150

G51714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G51714

CM. - 109384

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 920 N. Central Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rowlette, Bernice

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 31-1924

8. AGE: Years	Months	Days	If less than one day
22	6	13 14	hr. min.

9. Birthplace MD
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Samuel Rowlette
13. Birthplace VA.

MOTHER
14. Maiden Name Ronnie Brown
15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 5-17-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. Co.

18 (a) Funeral director Samuel W. Sullivan
(b) Address 1011 N. Arlington Ave

19 MAY 15 1947 Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 - 1947 2:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 24 1947 to May 14 1947 and that I last saw h 9F alive on May 14 - 1947

Immediate cause of death Pulmonary Tuberculosis, Far. Advanced — Duration 6 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Refused

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Hunt M. D.
Address Balt. City Hosp. Date signed 5/15/47

C51715

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1647

Registered No. C51715

PLEASE WRITE PLAINLY. WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 318 N. Fulton Street
(If rural give location)
(e) Citizen of foreign country? X (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES D. SHILLING

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 213-14-4072

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-16-1921

8. AGE: Years 26 | Months 2 | Days 28 | If less than one day hr. min.

9. Birthplace Frederick Co. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Grayson B. Shilling
13. Birthplace Frederick Co. Md.

MOTHER 14. Maiden Name Blanche C. O'Hara
15. Birthplace Frederick Co. Md.

16 (a) Informant Mrs. J. VanAcore
(b) Address Frederick - Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 17-1947 (month) (day) (year)
(c) Cemetery or [redacted] Mt. Olivet
Location Frederick, Md.

18 (a) Funeral director C. E. Cline & Son
(b) Address Frederick - Md.

19 (Date rec'd by registrar) MAY 15 1947 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14, 1947, at 7:45 P. M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hemorrhage due to incised wounds of wrists

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-14-47 at 6:45 P. M.
(b) Where did injury occur? 318 N. Fulton Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Slashed wrists with sharp instrument

23. Signature John R. Davis M.D. per [signature] Medical Examiner. M.D.
Date signed 5-15-47

VS 151

X

G51716

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 166

Registered No. G51716

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1833 N. Washington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Spinosa

3 (b) If veteran, name war

3 (c) Social Security Account No. 129-12-6106

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Vincent Spinosa

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27-1909

8. AGE: Years 37 | Months 9 | Days 17 | If less than one day hr. min.

9. Birthplace Balto Md.
(Town, county or state)

10. Usual Occupation Factory Worker

11. Industry or business

FATHER
12. Name John Rosso
13. Birthplace Italy

MOTHER
14. Maiden Name Unknown
15. Birthplace Carmel Maggio - Italy

16 (a) Informant Fannie Di Maggio
(b) Address Cherry Hill Rd

17 (a) Burial (b) Date thereof 5/17/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Balto Md.

18 (a) Funeral director Joseph Farace Inc
(b) Address 208 Greenmount Ave

19 (Date rec'd by registrar) MAY 15 1947 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14, 1947 at 7.30 A M

21. I certify that I took charge of the remains described above, held an insp. & inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Bullet Wound of Brain

Due to

Other Conditions Bullet Wound of Chest
Bullet wound left thigh.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-14-47 at 7 a. M.
(b) Where did injury occur? 1833 N. Wash. St. Baltimore, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearms

23. Signature Earle L. Royer M.D.
Medical Examiner.
Date signed 5-14-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G51717

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164c

Registered No. G51717

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 8-
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) 5
(d) Street No. 1833 N. Washington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vincent Spinosa

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-22-1835

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Minnie Spinosa

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years 45 | Months | Days | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER
12. Name Frankenowed
13. Birthplace Gaetano Spinosa Italy

MOTHER
14. Maiden Name Frankenowed
15. Birthplace Zula Rainiolo Italy

16 (a) Informant Mike Raymond
(b) Address Spalding Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/11/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md.

18 (a) Funeral director Joseph Favorite Inc
(b) Address 2003 Freemont Ave

19 MAY 15 1947 (Date rec'd by registrar) Hunting for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14, 1947, 9:15 A.M.

21. I certify that I took charge of the remains described above, held an insp. & inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet Wound of Brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-14-47 7 a. M.
(b) Where did injury occur? 1833 N. Wash. St. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearms

23. Signature Carl L Kaye M.D. Medical Examiner.
Date signed 5-14-47

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G51718 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1006 Argyle Ave,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1006 Argyle Ave, (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George G. Matthews.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	C.	Divorced

6 (b) Name of husband or wife Elsie Wood Matthews
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1896

8. AGE: Years	Months	Days	If less than one day
50	10	7	hr. min.

9. Birthplace Cambridge, Md.,
(Town, county, and state)
10. Usual Occupation Longshoreman
11. Industry or business

FATHER
12. Name George Matthews.
13. Birthplace Md.,

MOTHER
14. Maiden Name ?
15. Birthplace Md.

16 (a) Informant Lucille Fisher.
(b) Address 1006 Argyle Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-15-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mrs Kate R. Williams
(b) Address 322 A Schroeder St.

19 (a) MAY 15 1947 (Registrar's record) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-11- 1947, at 2:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-5- 1947 to 5-11- 1947 and that I last saw him alive on 5-11 1947

Immediate cause of death
Lobar Pneumonia — 9 days
Due to Tuberculosis Ed — 7 days
Due to Tumor Bill
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. H. Blake
Address 1227 N. Central Ave

X 5-15-47.

G51719

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30E

Registered No. G51719

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 23 N. Mount St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-2
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 23 N. Mount St. (If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME Margaret Pearl Fortie (Maggie Forty) ✓

3 (b) If veteran, name war: —
3 (c) Social Security Account No.: —

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: widowed
6 (b) Name of husband or wife: Eugene Fortie.
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) Feb 19, 1888

8. AGE: Years	Months	Days	If less than one day
59	2	23	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Printer
11. Industry or business Commercial Printer

FATHER
12. Name Robert Green
13. Birthplace Barbados, B.W.I

MOTHER
14. Maiden Name Maria Jones
15. Birthplace Howard Co. Md.

16 (a) Informant Mrs. Thelma Flowers
(b) Address 23 N. Mount st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-15-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn.
Location
18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St
19 (a) (Date received by Registrar) MAY 15 1947 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5.12.47 19 , at 8 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4.27.47 19 , to 5.12.47 19 , and that I last saw her alive on 5.12.47 19

Immediate cause of death	Duration
Left heart failure	5.12.47
Due to myocarditis,	?
Due to	?
Other Conditions Left hemiplegia, Deabetes ulcers	aug. 1943

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James M. Fair M. D.
Address 406 N. Carrollton Ave Date signed 5.12.47

VS 3

PRINT WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51720

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G51720

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 123 N. Fremont Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 123 N. Fremont ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adelle Johnson.
3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife George
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) 7-4-1896
8. AGE: Years 50 | Months 10 | Days 19 | If less than one day ____ hr. ____ min.
9. Birthplace Maryland (town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant George Johnson.
(b) Address 123 N. Fremont.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-16-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn, Cem
Location Baltimore Md
18 (a) Funeral director William G. Jackson
(b) Address 916 Penna ave
19 (a) MAY 15 1947 (b) [illegible] for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1947. 11 P. M
21. I certify that death occurred on the date above stated; that I attended deceased from 1947 to May 13 1947.
and that I last saw h[illegible]ive on May 13 19
Immediate cause of death Myocarditis — Duration 2 months
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature F. B. Funk M. D.
Address 1001 N. Fremont Ave Date signed May 15

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51721

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94 A

Registered No. G51721

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3304 W. Garrison Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 1 8
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3304 W. Garrison
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Raphael Zemel

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Anna
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years 56 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Merchant.

11. Industry or business

FATHER 12. Name Hyman
13. Birthplace Russia

MOTHER 14. Maiden Name Rebecca
15. Birthplace Russia

16 (a) Informant Wife
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-16-47 (month) (day) (year)
(c) Cemetery or crematory Herring Run
Location Phil. Rd

18 (a) Funeral director Jacob Lewis Inc
(b) Address 143 E. Balto St.

19 (a) MAY 15 1947 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-14-47 19 ____ at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from — 1945 to 5/14 1947.
and that I last saw h[illegible] alive on 5/14 1947

Immediate cause of death: acute cardiac dilatation — Duration
Due to: Coronary sclerosis
Due to: Hypertension & arteriosclerosis
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Herman Seidel M.D.
Address 2404 Eutaw Place Date signed 5/15/47

H. Seidel

VS 150

G51722

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82

Registered No. G51722

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2430 Ellamont St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2430 Ellamont St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM LESTER HAMPSHIRE

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Sara P. Hampshire nee Headley 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 23, 1898

8. AGE: Years	Months	Days	If less than one day
48	8	20	hr. min.

9. Birthplace Parkton, Balto. Co., Md. (Town, county, and state)
10. Usual Occupation Maintenance Manager
11. Industry or business Gas & Elec. Co.

FATHER
12. Name Wm. A. Hampshire
13. Birthplace Parkton, Balto. Co., Md.

MOTHER
14. Maiden Name Mary L. Kirk
15. Birthplace Parkton, Balto.Co., Md.

16 (a) Informant Mrs. Sara Hampshire
(b) Address 2430 Ellamont St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/16/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAY 15 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 to 5-12-1947 and that I last saw h. alive on 5-12-1947.

Immediate cause of death	Duration
Myocardial failure	
Due to Chronic Progressive	
Due to muscular atrophy	9 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J. Hood M. D.
Address 2210 Garrison Blvd Date signed 5-14-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51723

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G51723

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1101 Key Highway
(c) Hospital or institution: Dispensary-Bethlehem Steel Co. 13-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2225 Orem Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Marion Owings

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Nesta Owings (nee Castele)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 24, 1902

8. AGE: Years	Months	Days	If less than one day
44	7	20	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business Wallace & Gale Co.

FATHER
12. Name James M. Owings
13. Birthplace Unknown

MOTHER
14. Maiden Name Emma Dunn
15. Birthplace Balto.

16 (a) Informant Mrs. Nesta Owings
(b) Address 2225 Orem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/17/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAY 15 1947 (To be filled in by registrar) Huntington Williams, M.D.

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MEDICAL CERTIFICATION

20. DATE OF DEATH May 14, 1947, at 8 a.m.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-14-47 about 7 a. M.
(b) Where did injury occur? 1101 Key Highway Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Fell on deck of ship

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 5-14-47

X

G51724

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 77

Registered No. G51724

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. 17 (If outside city or town limits, write RURAL and give town)
(d) Street No. 602 W. Northern ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ora E. Pierce

3 (b) If veteran, name war	3 (c) Social Security Account No.
?	?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19, 1885

8. AGE: Years	Months	Days	If less than one day
62	2	26	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Balto. City Highway Dept.

FATHER
12. Name Emanuel Pierce
13. Birthplace Maryland

MOTHER
14. Maiden Name Alice Triplett
15. Birthplace Maryland

16 (a) Informant Wilbur O. Pierce
(b) Address 2141 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/17/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 MAY 15 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-14 1947 at 7 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-7 1947 to 5-14 1947 and that I last saw him alive on 5-13 1947

Immediate cause of death	Duration
Cardiac Failure	5 min.
Due to Delerium Tremens and Alcoholic Psychosis	5 days
Due to Epidermoid Alcoholism	2 days 8 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature William D. Keeley Jr. M.D.
Address Mercy Hospital Date signed 5-19-47

VS 150

X

G51725

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G51725

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Denison St.
(c) Hospital or institution:
Edgewood Nursing Home 16-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1129 Poplar Grove St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME TREPHENA COULLING

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife David Coulling
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 7, 1866

8. AGE: Years	Months	Days	If less than one day
81	2	6	hr. min.

9. Birthplace Dorchester Co., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ? Marine
13. Birthplace Md.

MOTHER
14. Maiden Name Martha ?
15. Birthplace Md

16 (a) Informant Mr. David Coulling
(b) Address 1129 Poplar Grove St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/16/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAY 15 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13, 1947 at 11:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 28 1947 to May 13 1947.
and that I last saw her alive on May 13 1947.

Immediate cause of death: (Duration)
Pneumonia 2 wks
Due to
Due to
Other conditions Carcinoma of Breast. (Include pregnancy within 3 months of death) under
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 11 W. 25th St. Date signed May 15 47

VS 150

X

G51726

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

✓ G51726 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 318 S. Ann Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-7
(e) Length of stay in Baltimore (yrs., mos., or days) 68 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 318 S. Ann Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME KAZIMIR ROMENSKI (RUMINSKI)

3 (b) If veteran, name war ---
3 (c) Social Security Account No. ---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Augusta
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) March 4, 1873

8. AGE: Years	Months	Days	If less than one day
74	2	9	..... hr. ..... min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John Ruminski
13. Birthplace Poland

MOTHER
14. Maiden Name Maryanna Kaczan
15. Birthplace Poland

16 (a) Informant Mrs. Augusta Romenski
(b) Address 318 S. Ann Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 16, 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location German Hill Road

18 (a) Funeral director M. F. Sadowski & Son
(b) Address 1808 Eastern Avenue

19 (a) ..... (Date rec'd by registrar) Huntington Hillendahl

MAY 15 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1947, 10:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1 1947 to May 13 1947 and that I last saw h[illegible] alive on May 12 1947

Immediate cause of death	Duration
Myocardial Insufficiency	3wks.
Due to Chronic Myocarditis	3yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John V. Kazubski
Address 1802 Eastern Ave Date signed 5-14-47 M.D.

X

G51727

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G51727 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1712 HANOVER ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1712 HANOVER ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY. A- HEYING

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex FEM.

5. Color or race WHITE

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife WILLIAM J. HEYING

6 (c) If alive, give age 2 years

7. Birth date of deceased (mo., day, yr.) FEB-25-1875

8. AGE: Years 72 | Months 2 | Days 19 | If less than one day hr. min.

9. Birthplace BALTIMORE MD (Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business

FATHER
12. Name FRANZ BREMMER
13. Birthplace GERMANY.

MOTHER
14. Maiden Name BARBARA ?
15. Birthplace GERMANY.

16 (a) Informant FRANK W HEYING
(b) Address 1712 HANOVER ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAY 17-47 (month) (day) (year)
(c) Cemetery or crematory HOLY CROSS
Location A.A. Co

18 (a) Funeral director Bernard E Hasle
(b) Address 121 E West St

19 (a) Filed by registrar (b) Washington Nathaniu, Md Registrar

MAY 15 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY - 14 1947, at 8 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1946 to May 14 1947.
and that I last saw her alive on May 14 1947.

Immediate cause of death — Duration
Exhaustion — 3 days.
Due to Carcinoma of breast — Indef.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. E. Campbell M.D.
Address 1647 Harwood Date signed 5-14-47

Dr. G51728

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 ✓ Registered No. G51728

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 324 East 22nd Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 324 East 22nd Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CHARLES BOWEN TIPTON

3 (b) If veteran, name war ----
3 (c) Social Security Account No. -----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Martha Jane Tipton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1857

8. AGE: Years	Months	Days	If less than one day
90			hr. min.

9. Birthplace Jarrettsville, Harford (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name Wm. B. Tipton
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine Dietz
15. Birthplace Pa.

16 (a) Informant Mr.L.W.Tipton
(b) Address 324 East 22nd Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/16/47 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location City

18 (a) Funeral director WIEDEFELD AND SON
(b) Address GREENMOUNT AVE & 22ND

19 5 1947 (a) Rec'd by [illegible] (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14th, 1947, at 5:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1924 to May 14 1947 and that I last saw h[illegible] alive on May 13 1947

Immediate cause of death [illegible] Heart — Duration 30 min

Due to Myo-[illegible]

Due to [illegible] Senility — Duration 4 years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 2424 St. Paul St Date signed May 14-47

X

G51729
AB-63895

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 132

Registered No. G51729

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 11-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3yrs- 8mos- 26days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 424 Cummings Court-McCulloh
(If rural give location) Project
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy Mayo

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 12- 1914

8. AGE: Years	Months	Days	If less than one day
33	4	1	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Samuel McCay (D) or-Samuel McCoy
13. Birthplace S.C.

MOTHER
14. Maiden Name Hattie Harris
15. Birthplace N.C.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 17/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A County, Md

18 (a) Funeral director Mrs. Robt. A. Elliott & Dept.
(b) Address 1129 N. Caroline St

19 (a) (Date received by local registrar) MAY 15 1947 (Signature of local registrar) Huntington Nitkewicz, Asst.

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13- 1947, at 12.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-12- 1947 to 5-13- 1947 and that I last saw her alive on 5-13- 1947

Immediate cause of death Adenocarcinoma, Intestines, Far-advanced — Duration 4 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Refused

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wallace J. Hunt M. D.
Address Balt. City Hospitals Date signed 5-13-47

G51730

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G51730

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3300 Ellerslie ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3300 Ellerslie ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Ow. Lutz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23-1869

8. AGE: Years 78 | Months | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER
12. Name Samuel Markley
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Grace Christofor
15. Birthplace Baltimore Md.

16 (a) Informant Miss Rose Lutz
(b) Address 3300 Ellerslie Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 12-47 (month) (day) (year)

(c) Cemetery or crematory Most Holy Redeemer
Location Baltimore Md.

18 (a) Funeral director Jeannie C. Lyffer
(b) Address 1600 N. Nastle Ave.

19 (a) MAY 15 1947 (Date Received) (b) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1947, at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 22 1947 to May 13, 1947 and that I last saw her alive on May 12, 1947

	Duration
Immediate cause of death: Coronary occlusion	1 MO.
Due to: Arteriosclerosis	1 yr.
Due to:	
Other Conditions: Cataracts	1 yr.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Clark Dingeldey
Address 1613 E. North Ave. Date signed 5-14-47

G51731

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a ✓

Registered No. G51731

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3512 Clifton Ave
(c) Hospital or institution: none 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County none
(c) City or town 3512 Clifton Ave. (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Philip Fangmeyer

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Ida Wolfe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 20, 1888

8. AGE: Years	Months	Days	If less than one day
58	7	24	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Investigator for State
11. Industry or business

FATHER
12. Name Charles Fangmeyer
13. Birthplace Baltimore

MOTHER
14. Maiden Name Lillie Knatz
15. Birthplace Baltimore

16 (a) Informant Ida C. Fangmeyer
(b) Address 3512 Clifton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/17/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place Washington Williams, Mgr.

MAY 15 1947 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14, 1947, at 10:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 14, 1947, to May 14 1947, and that I last saw h[illegible] alive on May 14 1947.

Immediate cause of death	Duration
Coronary Thrombosis	6 hours
Due to Coronary Arteriosclerosis	Unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham B. Hurwitz M. D.
Address 3049 W. North Ave. Date signed May 15, 1947

VS 130

G51732

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 77

Registered No. G51732

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 817 N. Appleton St.
(c) Hospital or institution: none 16-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 817 N. Appleton St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME John A. Perkins

3 (b) If veteran, name war No

3 (c) Social Security Account No.

4. Sex male

5. Color or race White

6 (a) ~~Single, married, widowed, or~~ divorced. divorced

6 (b) Name of husband or wife Ruth Olivia Plummer

6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) June 21. 1900

8. AGE: Years 46 Months 10 Days 22 If less than one day ... min.

9. Birthplace Baltimore Va. (Town, county, and state)

10. Usual Occupation Paper hanger

11. Industry or business

FATHER 12. Name Harvey Lee Perkins

FATHER 13. Birthplace Balto, Md

MOTHER 14. Maiden Name Martha E. Flowers

MOTHER 15. Birthplace Balto

16 (a) Informant Martha E. Thomas

(b) Address 817 N. Appleton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 16/47 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location 3801 Frederick Ave

18 (a) Funeral director John O. Mitchell & Sons

(b) Address 1906 Eutaw Place

19 (a) MAY 15 1947 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1947 at 3:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 9 1947, to May 13 1947, and that I last saw h[illegible] alive on May 12 1947.

Immediate cause of death Coma Intestinal Tox — Duration 2 weeks

Due to Abuse of alcohol

Due to Anemia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation No.

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No.
(b) Date of occurrence , at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, in industrial place, in public place? While at work?
(Specify one of place)
(e) Means of injury

23. Signature John A. Travis M. D.
Address 1612 W 40 St. Date signed

VS 150

G51733

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30 E

Registered No. G51733

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 106 N. Pearl St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Leo Edwards

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Col

6 (a) Single, married, widowed, or divorced: Sep.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1900

8. AGE: Years 47 | Months | Days | If less than one day hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Musician

11. Industry or business

FATHER
12. Name: Thomas Edwards
13. Birthplace: unknown

MOTHER
14. Maiden Name: Josephine Duff
15. Birthplace: unknown

16 (a) Informant: Sylvia Dayton
(b) Address: 106 N. Pearl St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/14/47 (Monthly) (day) (year)
(c) Cemetery or crematory: Mt Calvary
Location

18 (a) Funeral director: Elroy Wilson
(b) Address: 1000 Brantly Ave

19 MAY 15 1947 (Date received by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-13- 1947, at 3:7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-28-1947 to 5-13-1947, and that I last saw him alive on 5-13-1947.

Immediate cause of death	Duration
Peripheral Circulatory Collapse.	
Due to Cardio-vascular accident-??	
Due to	
Other Conditions Hypertrophy & dilatation & decomp. grade IV (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harvey M. D.
Address Univ. Hosp. Date signed 5-13-47

VS 150

G51734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G51734

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cause is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1601½ Webster St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1601½ Webster St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Emma E. Frommknecht

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Widowed.

6 (b) Name of husband or wife Pancratius L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-3-1875

8. AGE: Years 72 | Months 4 | Days 10 | If less than one day hr. min.

9. Birthplace Birmingham and Cond (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name George Greaves
13. Birthplace England

MOTHER
14. Maiden Name Anna Mason
15. Birthplace England

16 (a) Informant Leo P. Frommknecht
(b) Address 1601½ Webster St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-17-47 (month) (day) (year)
(c) Cemetery or crematory Woodbridge Mem. Park
Location Elkridge, Md

18 (a) Funeral director J. Howard Strong
(b) Address 3207 N. North Ave

19 (a) MAY 15 1947 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1947 at 12.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-1 1945, to 5-13 1947, and that I last saw h[illegible] alive on 5-12 1947.

Immediate cause of death	Duration
Chronic Myocardial Degeneration	2 yr.
Due to Arteriosclerosis	2 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. H. Ballard M. D.
Address 707 Fort Ave. Date signed 5-13-47

VS 150 Funeralization Williams, MD

G51735

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

Registered No. G51735

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address DUKELAND + RAYNER AVES.
(c) Hospital or institution: WEST BALTIMORE GENERAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County York
(c) City or town Hanover
(If outside city or town limits, write RURAL and give town)
(d) Street No. High St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARY CARBAUGH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife BERNARD
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 1, 1886

8. AGE: Years	Months	Days	If less than one day
60	1	14	hr. min.

9. Birthplace Pennsylvania
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

MOTHER / FATHER
12. Name Frank Bunty
13. Birthplace Adams County, Pa.
14. Maiden Name Sarah Dilwood
15. Birthplace Adams County Pa.

16 (a) Informant Albert Rubenstein, MD
(b) Address West Baltimore General Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 18 1947 (month) (day) (year)
(c) Cemetery or crematory St. Joseph's Cemetery
Location Hanover Pa.

18 (a) Funeral director W. A. Keeser
(b) Address Hanover Pa.

MAY 15 1947 (Date received by registrar) Huntington for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/15 1947, at 2:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/8 1947 to 5/15 1947 and that I last saw her alive on 5/15 1947.

Immediate cause of death TOXEMIA — Duration

Due to INFECTED AMPUTATION STUMPS + DECUBITUS ULCERS

Due to DIABETES MELLITUS

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert Rubenstein
Address 3008 W. North Ave Date signed 5/18/47 M.D.

X

G51736 OA# D-74262 DUPLICATE

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G51736

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd - Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore 10
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3625 Keswick Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Watkins

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 22, 1947

8. AGE: Years	Months	Days	If less than one day
		21	5 hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name William Tracey Watkins
13. Birthplace Maryland

MOTHER
14. Maiden Name Carl Greentree
15. Birthplace Baltimore, MD.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Hospital

18 (a) Funeral director Disposal
(b) Address

19 (a) (Burial permit issued by) (b) Huntington-Williams Mt

MAY 16 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1947, at 5:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/22 1947 to 3/23 1947, and that I last saw h/a alive on 3/23 1947.

Immediate cause of death	Duration
Prematurity	
(EDC 3/5/47)	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 0
Major findings of operation: 0
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Malcolm G. Hunt M. D.
Address Union Memorial Hosp. Date signed 3/24/47

X

G51737

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46H

Registered No. G51737

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1002, 23rd St
(c) Hospital or institution: Dr Beck St Paul. 23rd St. 4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 23 S. Liberty Sts
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alling Courtland Cole

3 (b) If veteran, name war: W. W. #1
3 (c) Social Security Account No. 712-01-5446

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Ann C. Cole
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 1st 1893

8. AGE: Years	Months	Days	If less than one day
54	1	13	hr. min.

9. Birthplace: N. Y.
(Town, county, and state)
10. Usual Occupation: Mechanical Engineer
11. Industry or business: Sanderson & Porter

FATHER
12. Name: John P. Cole
13. Birthplace: Un Known

MOTHER
14. Maiden Name: Florence "
15. Birthplace: "

16 (a) Informant: Ann C. Cole
(b) Address: 26 S. Liberty St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/17/47 (month) (day) (year)
(c) Cemetery or crematory: U. S. National
Location: Balto, Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul St

19 (a) MAY 16 1947 (Date received by Local Registrar) (b) Curtis for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 14th 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 9 1947 to May 14 1947 and that I last saw h[illegible] alive on May 14 1947.

Immediate cause of death	Duration
Retroperitoneal Sarcoma	Indefinite
Due to	
Due to	
Other Conditions: Partial obstruction of lower colon 2ndary to above (Include pregnancy within 3 months of death)	Indefinite

Date of operation: None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Nathaniel M Beck M. D.
Address: 1002 E. 23rd St Date signed: May 15-47

VS 150

G51738

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 153

Registered No. G51738

Bl# Gr 54191

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 628 W. Hamburg St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 628 W. Hamburg (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Darlene Agnes Normann

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: —

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 19 - 1946

8. AGE: Years | Months: 8 | Days: 25 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER 12. Name Frank Wilson Normann
13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Agnes L. O'Brien
15. Birthplace Baltimore Md.

16 (a) Informant Fr. Wilson Normann
(b) Address 628 W. Hamburg

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 16-47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Sec 61 Regent 4 Ph

18 (a) Funeral director E. Elizabeth Hagle Fun. Dir.
(b) Address 115 E. West St.

MAY 16 1947 (Date rec'd by Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1947, at 7:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 4th 1946 to May 14 1947 and that I last saw h[illegible] alive on May 14 1947.

Immediate cause of death	Duration
Staphylococcic Septicemia	24 hrs.
Due to Erythrodermia Desquamativa	7½ mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard Smith M.D.
Address 11 E. Chase St. Date signed 5/15/47

VS 190

C51739

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 8.3a

C51739 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5114 St. Georges Avenue
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) –
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 5114 St. Georges Avenue
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ellen Caroline LeFevre

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 4, 1864

8. AGE: Years	Months	Days	If less than one day
82	24	11	hr. min.

9. Birthplace Northumberland Co., Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Capt. George LeFevre
13. Birthplace Virginia

MOTHER
14. Maiden Name Caroline Sharwood Livingston
15. Birthplace Salisbury, Maryland

16 (a) Informant Mrs. Carolina Sharmond
(b) Address 5114 St. Georges Ave.

17 (a) Butial (b) Date thereof May 17
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cemetary
Location Greenmount Balt. Md

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul St.

MAY 16 1947 (b) Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 5 1947 to May 15 1947 and that I last saw h[illegible] alive on May 14 1947

Immediate cause of death Cerebral Hemorrhage — Duration 3 days
Due to cerebral accident — Duration 7 days
Due to age
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury
23. Signature H. H. Hewson
Address 1 Overwood Rd. Date signed 5-15-47

G51740

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G51740

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2726 Harlem Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2726 Harlem Ave.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME: Margaret E. Heinmuller

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NO

4. Sex: FM

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: George Heinmuller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): August 11, 1877

8. AGE: Years 69 | Months 9 | Days 3 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business: Home

FATHER
12. Name: Conrad Lober
13. Birthplace: Germany

MOTHER
14. Maiden Name: Caroline Wagner
15. Birthplace: Baltimore, Maryland

16 (a) Informant: Mr. Vernon Heinmuller
(b) Address: 2726 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 5/17/47 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore, Maryland

18 (a) Funeral director: George W. Little
(b) Address: 2700 Edmondson Ave.

19 (a) Date received (b) (Registrar): MAY 16 1947 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 14 1947, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-15-47 19 to 5-14-47 19, and that I last saw h[illegible] alive on 5-[illegible]-47 19

Immediate cause of death: Uremia
cerebral Hemorrhage
Duration: 3 days 5 days

Due to: Hypertension

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Mary L. Lembl M. D.

Address: 2703 Edmondson Date signed: 5-15-47

G51741

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G51741 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 306 Woodlawn Road
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 306 Woodlawn Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Amy C Guyton

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F.
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband ~~or wife~~ Samuel V. Guyton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 16, 1863

8. AGE: Years 83 | Months 7 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Henry Gibson
13. Birthplace London, England

MOTHER
14. Maiden Name Caroline Anne Hayes
15. Birthplace Oxford, England

16 (a) Informant Mrs. Evelyn M Dickey
(b) Address 306 Woodlawn Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5- -47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto.-Md.

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (E. F. Woods Suc.) 100 N. Howard Avenue

19 MAY 16 1947 (b) Huntington Williams, M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1947, at 12:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1947, to May 15 1947, and that I last saw her alive on May 15 1947.

	Duration
Immediate cause of death: Arteriosclerotic cardiovascular disease	1 yr.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature Frances M. Gluck M. D.
Address 713 Park Ave Date signed 5/15/47

G51742

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G51742 Registered No.

131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 1506 N. Appleton St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Wise
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Dora
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years	Months	Days	If less than one day
53			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER 12. Name Not known
13. Birthplace Russia

MOTHER 14. Maiden Name Not known
15. Birthplace Russia

16 (a) Informant Wife
(b) Address

17 (a) Burial (b) Date thereof 5-16-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Herring Run
Location Old Rd.

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Baltimore St

MAY 16 1947 per Livingston Williams, M.D. Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-15 1947, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-11 1947 to 5-15 1947 and that I last saw h[illegible] alive on 5-15 1947

Immediate cause of death	Duration
Hypertension	
Chronic Nephritis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan B. Hyman M. D.
Address Sinai Hosp Date signed 5-18-47

V S 150

X

C51743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √46 B

Registered No. C51743

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2476 Harley Ave
(c) Hospital or institution: Mt Carmel Home 6 1/4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2034 E. Balto St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sophia Rosen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1877

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Abraham
13. Birthplace Russia

MOTHER
14. Maiden Name Hindy
15. Birthplace Russia

16 (a) Informant Samuel Rosen
(b) Address 2034 E Balto St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-16-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1404 E Balto St

MAY 16 1947 (b) Huntingtown Williamsport Md
(Date received) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-15-1947 6P M

21. I certify that death occurred on the date above stated; that I attended deceased from January 13 1947 to May 15 1947 and that I last saw h[illegible] alive on May 15 1947

Immediate cause of death Carcinomatosis — Duration 1 yr

Due to

Due to

Other Conditions arteriosclerosis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert S. Rosen M. D.
Address 3700 Park Heights Ave Date signed May 16 1947

VS 150

G51744 / Transcript

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46M

G51744 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ORIGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: Church Home & Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 46
(e) Length of stay in Baltimore (yrs., mos., or days) 46

2. USUAL RESIDENCE OF DECEASED:
(a) State Florida (b) County —
(c) City or town Hollywood (If outside city or town limits, write RURAL and give town)
(d) Street No. 1312 Polk Sheet (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Jean DeStelacke

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widowed
6 (b) Name of husband or wife: dead
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) Oct. 15 1881
8. AGE: Years 65 Months 6 Days 17 If less than one day ..... hr. ..... min.
9. Birthplace Poland (Town, county, and state)
10. Usual Occupation artist
11. Industry or business —

FATHER
12. Name Kazimierz DeStelacke
13. Birthplace Poland

MOTHER
14. Maiden Name Kazemera, Slizzyzowski
15. Birthplace Poland

16 (a) Informant Mrs Charles E. Burden
(b) Address 37-28 86th St Jackson Heights Long Island N.Y.
17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof May 16/47
(c) Cemetery or crematory Loudon Park
Location Balto Md.
18 (a) Funeral director Henry H. Stritzke
(b) Address 1401 Edmondson Ave
MAY 16 1947 (Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-14 1947 at 4 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 3-22 1947 to 5-14 1947 and that I last saw him alive on 5-14 1947

Immediate cause of death	Duration
Cachexia	
Due to Generalized Carcinomatosis ? G.I. Origin	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 4-19-47
Major findings of operation: Carcinomatosis
of autopsy Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lois T. Jordan. M. D.
Address Church Home Hospital Date signed 5-14-47

G51745

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G51745 Registered No.

MARGIN RESERVED FOR BINDING

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2603 Dulaney St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2603 Dulaney St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Enoch Parrish Sr

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Beulah M. Wolf

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 3 (1880) 1884

8. AGE: Years (66) 63 | Months 3 | Days 13 17 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Window Washer

11. Industry or business Own Business

FATHER
12. Name John H Parrish
13. Birthplace Md

MOTHER
14. Maiden Name Susan R Metcafe
15. Birthplace Md

16 (a) Informant Mrs. Beulah Parrish
(b) Address 2603 Dulaney St

17 (a) Burial (b) Date thereof 5/17/47 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Balto Md

18 (a) Funeral director Harry A Wilkie
(b) Address 4016 Edmondson Ave

MAY 16 1947 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945 to May 13 1947 and that I last saw him alive on May 14 1947.

Immediate cause of death: (a) Acute Cardiac Dilitation — Duration: Minutes
Due to: Hypertension Cerebral Vascular disease — Duration: 2 years
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Stevenson M. D.
Address 2687 Madison Ave Date signed May 15 1947

G51746 G51746

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 148a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1506 N. Fremont Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1506 N. Fremont Ave (If rural give location)
(e) Citizen of foreign country? Md. (Yes or No)
If yes, name country

3 (a) **FULL NAME** Aline Smith

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F.
5. Color or race Col.
6 (a) Single, married, widowed, or divorced. M.
6 (b) Name of husband or wife Laurence Smith
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 28, 1919

8. AGE: Years 28 Months 2 Days 16 If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Bernie Campbell
13. Birthplace Maryland

MOTHER
14. Maiden Name Edna Smith
15. Birthplace Maryland

16 (a) Informant Laurence Smith
(b) Address 1506 N. Fremont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/16/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md.

18 (a) Funeral director Wm. H. Kelson
(b) Address 1203 Pennsylvania Ave

19 MAY 16 1947 (Date rec'd by Reg.) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-13- 1947, at 2:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-4- 1947 to 5-13- 1947 and that I last saw h. alive on 5-13- 1947

Immediate cause of death Carcinoma Cervix — Duration 1 yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George C. Page M.D.
Address 1816 N. Monument St. Date signed 5-15-47

VS 150

G51747

BC# F42276

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G51747

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3028 Matthews St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Steven Lee Parault

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Child

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4, 1942

8. AGE: Years	Months	Days	If less than one day
5	4	11 10	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name James M. Parault
13. Birthplace Reistertown, Md.

MOTHER
14. Maiden Name Ruth V. Moyer
15. Birthplace Baltimore, Md.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (b) Date thereof 5/16/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) May 16 1947 (b) Huntington Williams M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1947, at 8:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 25 1947 to May 14 1947 and that I last saw him alive on May 14 1947.

Immediate cause of death	Duration
Lymphosarcoma generalized	3 mos.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Lewis, Jr. Asst. Surgeon (R) U. S. P. H. S.
Address US Marine Hospital Baltimore, Md. Date signed 5/15/47

G51748

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G51748 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Lyndhurst Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2117 Lyndhurst Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM STEWART HARTLOVE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Nora W. Hartlove (nee Callaway) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31, 1887

8. AGE: Years	Months	Days	If less than one day
59	11	13 14	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Wm. Watkins Hartlove
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mr. Wm. Hartlove
(b) Address 2117 Lyndhurst Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/17/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAY 16 1947 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

VS. 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14, 1947 at 7:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/14 1943 to 5/14 1947 and that I last saw him alive on 5/14 1947

Immediate cause of death	Duration
Cerebral hemorrhage	6 wks.
Due to Cerebral arteriosclerosis	3 mo.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert A. Reiter M. D.
Address 340 E Wyndover Ave Date signed 5/15/47

X

G51749

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G51749 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3707 Fernhill Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3707 Fernhill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HELEN STIRLING

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife Charles S. Stirlin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 28, 1870

8. AGE: Years	Months	Days	If less than one day
77	3	16	hr. min.

9. Birthplace Port Royal, Caroline Co., Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Daniel Atwill
13. Birthplace Pt. Royal, Caroline Co. Va.

MOTHER
14. Maiden Name Helen Emily Farinholt
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. C. S. Stirling
(b) Address 3707 Fernhill Ave.

17 (a) Burial (b) Date thereof 5/16/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAY 16 1947 (Date Rec'd by Local Registrar) Huntington Williams, M.D. Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14, 1947 at 6:04 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 3rd 1947 to May 14th 1947. and that I last saw h alive on May 13th 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	24 hrs
Due to Hypertension	1 week
Other Conditions	3 years

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. E. Poulton
Address 3909 Gannon Blvd Date signed 5/15/47 M. D.

G51750

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G51750
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edmondson and Mt. Holly
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 943 Linnard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN FERDINAND GOURLEY, SR.

3 (b) If veteran, name war: none
3 (c) Social Security Account No. 216-16-6855

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Agnes Estella Gourley
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug. 12, 1880

8. AGE: Years	Months	Days	If less than one day
66	9	3	hr. min.

9. Birthplace Nottingham, Md. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Sherwood Bros.

FATHER
12. Name John Gourley
13. Birthplace Ireland

MOTHER
14. Maiden Name Jane Methaney
15. Birthplace Va.

16 (a) Informant Mrs. Agnes E. Gourley
(b) Address 743 Linnard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/19/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 MAY 16 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/15 1947, at 6:25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C-V disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D. (Medical Examiner.)
Date signed 5/16/47

G51751

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30D

G51751 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lakewood & Grant Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt. Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 654 W. Franklin St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Christine Robeson

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-32-0915

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-30-1904

8. AGE: Years	Months	Days	If less than one day
43	3/12	17	hr. min.

9. Birthplace Wash. D.C. (Town, county, and state)

10. Usual Occupation Barmaid

11. Industry or business

FATHER
12. Name Thomas Dorsey
13. Birthplace Washington, D.C.

MOTHER
14. Maiden Name Mattie
15. Birthplace Washington, D.C.

16 (a) Informant Vivian Clark (Daughter)
(b) Address 654 W. Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/13/47 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem'l. Pk.
Location Balto. County, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N. Carrollton Ave.

19 (a) Date received by local registrar MAY 16 1947 (b) Signature of local registrar Hamilton Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-14- 1947 at 2:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-12- 1947 to 5-14 1947 and that I last saw her alive on 5-14 1947.

Immediate cause of death Resp. Failure — Duration

Due to Obstructing Carcinoma of rectum

Due to Acute Adenocystoma

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles H. Hardinge M. D.

Address University Hosp. Date signed 5-14-47

G51752 BC# 453496 BALTIMORE CITY HEALTH DEPARTMENT G51752
CERTIFICATE OF DEATH 115c

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Walbrook + Caton Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1845 Ramsay St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Michael D. Rumney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-8-46

8. AGE: Years | Months: 9 | Days: 7 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county and state)

10. Usual Occupation Infant

11. Industry or business

FATHER 12. Name Frank P. Rumney

13. Birthplace Md. Balto

MOTHER 14. Maiden Name Muriel M. Sullivan

15. Birthplace Md Balto

16 (a) Informant Muriel M. Rumney

(b) Address 1845 Ramsay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 17. 1947 (month) (day) (year)

(c) Cemetery or crematory Glen Haven

Location Balto Co Md

18 (a) Funeral Director Pfc G B. M. Walters

(b) Address Pratt + Stricker Sts

19 (a) MAY 16 1947 (Date received by registrar) (b) [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1947, 11:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-23 1947 to 5-15 1947 and that I last saw him alive on 5-15 1947.

Immediate cause of death: Resp. Death While under Ether Vinethene

Due to: Anesthesia for

Due to: Tonsillectomy (Chron. Tracheo Bronch.)

Other Conditions: Pneumonia Rt lower (chron. T. B.)

(Include pregnancy within 3 months of death)

Date of operation 15 May 47

Major findings of operation: Chron. Tonsillitis & Adenoiditis

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 5/15/47 at M
(c) Where did injury occur? St Agnes Hosp Balto Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Yes (Specify type of place) While at work? No
(e) Means of injury Operating table anesthesia

23. Signature H. E. McGrath M.D. M. D.

Address St. Agnes Hosp Date signed

Howard J. Mackin, M.D. 15 May 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51753

AB-110136

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G51753

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22days
(e) Length of stay in Baltimore (yrs., mos., or days) 25yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1006 Bennett Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Woods

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bessie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 29- 1895

8. AGE: Years 51 | Months 4 | Days 16 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas Woods
13. Birthplace Maryland

MOTHER
14. Maiden Name Catherine Simmons
15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 5-19-47 (month) (day) (year)
(c) Cemetery or crematory
Location LAUREL, MD.

18 (a) Funeral director CHARLES R. LAW
(b) Address 302 MADISON AVE.

19 (a) MAY 16 1947 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15- 1947, at 2.15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-23- 1947 to 5-15- 1947, and that I last saw h. alive on 5-15- 1947.

Immediate cause of death	Duration
Terminal Pneumonia	4 days
Due to C.N.S. Syphilis	2+ yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: NO POST.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edmund S. Beacham

Address Balto City Hosp. Date signed 15 May 47

X

Cappelletti

G51754

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V117a

G51754

Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Maryland General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Baltimore

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3719 Mt. Pleasant Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Nazzareno Augusto Cappelletti

3 (b) If veteran, name war none

3 (c) Social Security Account No. 213-07-3667

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 5 1896

8. AGE: Years	Months	Days	If less than one day
50	5	9	hr. min.

9. Birthplace Italy - (Town, county, and state)

10. Usual Occupation Steel worker

11. Industry or business B. Steel Co. Spar. Md.

FATHER 12. Name John Cappelletti

13. Birthplace Italy

MOTHER 14. Maiden Name Luigia Ovvi

15. Birthplace Italy

16 (a) Informant Gabriele Piunti

(b) Address 3918 Claremont St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 17/47 (month) (day) (year)

(c) Cemetery or crematory Moreland Park Cem.

Location Baltimore Md

18 (a) Funeral director Frank Della Rocca

(b) Address 52 N. Morley St.

19 (a) MAY 16 1947 (b) Huntington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1947, at 2:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw him alive on May 14 1947.

Immediate cause of death: Peritonitis

Uremia

	Duration

Due to

Due to

Other Conditions: Pneumonia

(Include pregnancy within 3 months of death)

Date of operation May 7, 1947

Major findings of operation: Pertic Ulcer.

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Edward Bartlett M. D.

Address Md. Genl. Hosp. Date signed May 15, 47

VS 150

G51755

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92E

G51755 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 214 E. Federal St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 31 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 214 E. Federal St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Hill

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 18-1882

8. AGE: Years	Months	Days	If less than one day
65	-	26	hr. min.

9. Birthplace A. A. Co. Maryland (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Lewis W. Estep
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Jane Pratt
15. Birthplace Maryland

16 (a) Informant Harrison Hill
(b) Address 1626 West Wood ave

17 (a) Burial (b) Date thereof 5-18-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Carter Chapel Friendship
Location A. A. Co

18 (a) Funeral director Raynes Sanders
(b) Address 1412 E. Preston St

19 (a) [illegible] 1947 (b) Huntington Williams M.D.
(Date received by registrar)

MAY 20 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1947, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 15th. 47 to May 14th. 47.
and that I last saw her alive on May 13th. 1947.

Immediate cause of death: Myocardial Insufficiency — Duration: about 1 yr.
Due to: ----
Due to: ------
Other Conditions: Endocarditis — unknown
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of death
23. Signature H. Montgomery M.D.
Address 401 E. 25th. St. Date signed 5/15/47.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51756

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G51756

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 501 Rosehill Terrace
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 501 Rosehill Terrace (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry A. Klug

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Esther Guest
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/21/1892

8. AGE: Years	Months	Days	If less than one day
54	6	14	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Stationer

FATHER
12. Name Phillip Klug
13. Birthplace Maryland

MOTHER
14. Maiden Name Ella Doblin
15. Birthplace Maryland

16 (a) Informant Mrs. Esther Klug
(b) Address 501 Rosehill Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof MAY 17 1947 (month) (day) (year)
(c) Cemetery or crematory Parkwood Mem
Location Taylor Ave

18 (a) Funeral director John E. Moran
(b) Address 3000 E Baltimore St

19 (a) MAY 16 1947 (Date received by local registrar) (b) Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1947, at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11 May 1947 to 14 May 1947 and that I last saw him alive on 14 MAY 1947.

Immediate cause of death	Duration
Due to Coronary Thrombosis	4 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lloyd E. Taylor M. D.
Address 3902 Greenmount Ave. Date signed 15 May 47

X

G51757

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V83a

Registered No. G51757

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hosp. 17 E. Lexington
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hours
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3314 Elm Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hugh Lego

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/17/1883

8. AGE: Years	Months	Days	If less than one day
64	2	27	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Gardner
11. Industry or business

FATHER
12. Name Amos Lego
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Creswell
15. Birthplace Md

16 (a) Informant Mary H Lego
(b) Address 3314 Elm Ave

17 (a) Burial (b) Date thereof May 17-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mountain Christian
Location Joppa Md

18 (a) Funeral director Frank H. Leek
(b) 1436 St Paul St for Williams Mort
(Date rec'd by registrar) (b) Registrar

MAY 16 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-14 1947, at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-14 1947 to 5-14 1947 and that I last saw him alive on 5-14 1947.

Immediate cause of death	Duration
Resp Failure	
Due to Cerebrovascular accident	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. B. Marshall Jr. M. D.
Address Univ Hosp Date signed 5-14-47

VS 150

G51758

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. G51758

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive and 31st St.
(c) Hospital or institution:
U. S. Marine Hospital, Balto., Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 days
(e) Length of stay in Baltimore (yrs., mos., or days) 28 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1113 N. Luzerne Ave., Balto., Md.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Maurice Jesse Fletcher

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Marie Belmart
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) June 1, 1890

8. AGE: Years	Months	Days	If less than one day
56	11	13	hr. min.

9. Birthplace Kittery Point, Maine
(Town, county, and state)
10. Usual Occupation Chief Engineer
11. Industry or business Merchant Seaman

FATHER
12. Name Lorenzo Fletcher
13. Birthplace Maine

MOTHER
14. Maiden Name Harriet ?
15. Birthplace Maine

16 (a) Informant Records
(b) Address U. S. Marine Hospital, Balto., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/19/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore National Location Frederick Ave.

18 (a) Funeral director Tully & Zeiler Co.
(b) Address 503 S. Wolfe St.

19 (a) (b)
MAY 16 1947 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14, 1947 19 at 9:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 17 1947 to May 14 1947, and that I last saw him alive on May 14 1947

Immediate cause of death (1) Anemia acute secondary due to aneurysm thoracic aorta rupture of — Duration Immediately preceding

Due to (2) Carcinoma bronchogenic left lower lung with metastases — UNKNOWN

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
As above
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 5/15/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51759

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Register No. G51759

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2005 Linden Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2005 Linden Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No

3 (a) FULL NAME Frances Lillean Whitehouse

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	married

6 (b) Name of husband or wife Albert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 2 - 1905

8. AGE: Years	Months	Days	If less than one day
41	9	13	hr. min.

9. Birthplace Florida
(Town, county, and state)

10. Usual Occupation Waitress
11. Industry or business White Coffee Pot Re

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Albert A. Whitehouse
(b) Address 2005 Linden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/17/47 (month) (day) (year)
(c) Cemetery or crematory St. Matthews
Location 6400 Bl. A Donnell Sts

18 (a) Funeral director Tilley & Zeiler
(b) Address 403 S. Adolph Street

19 (a) MAY 16 1947 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15, 1947, at 8 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 12, 1947 to May 14 1947, and that I last saw him alive on May 14, 1947

Immediate cause of death Hemiplegia — Duration 3 days
Due to Cerebral Hemorrhage a Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm Grunfeld M. D.
Address 1821 Eutaw Pl. Date signed 5/16/47

G51760

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 61

G51760 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address —
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days.
(e) Length of stay in Baltimore (yrs., mos., or days) Has been ever

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1707 W. Lexington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Hart

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Black	married

6 (b) Name of husband or wife Herbert Hart
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) 2 — 1, 1887

8. AGE: Years	Months	Days	If less than one day
60	3	13	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Home wife
11. Industry or business —

FATHER
12. Name Lawson Scales
13. Birthplace North Carolina

MOTHER
14. Maiden Name Matilda Martin
15. Birthplace North Carolina

16 (a) Informant Herbert Hart
(b) Address 1707 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 (month) 19 (day) 1947 (year)
(c) Cemetery or crematory Mt. Zion
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

MAY 16 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1947 at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 14 1947 to May 14 1947, and that I last saw her alive on May 14 1947.

Immediate cause of death: Septicemia — failure — Duration 1 day

Due to Bronchopneumonia and — unknown

Due to Arter. hyp. & cardiac degeneration, old — unknown

Other Conditions Diabetes Mellitus — 1 year

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy Yes, above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hayley B. Klyanowsky M.D.
Address Franklin Sq. Hosp. Date signed 5/15/47

94a

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51761

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

Registered No. G51761

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 416 N. Carey St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Virginia D. Gillison

3 (b) If veteran, name war.....
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife John Gillison
(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 3, 1890

8. AGE: Years	Months	Days	If less than one day
56 57	11	9	.....hr. .....min.

9. Birthplace Essex Co. Virginia (Town, county, and state)
10. Usual Occupation Housemaid
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Martha Cann (daughter)
(b) Address 416 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-16-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location.....

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 3221 Schroeder St.

19 (a) MAY 16 1947 Huntington Williams, M.D. (Registrar)
(b) Received by registrar.....

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12, 1947, at 9:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy + Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertension C.V. Renal Disease

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Earl L. Royer M.D. (Medical Examiner.)
Date signed.....

G51762

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

Registered No. G51762

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 109 N. Fremont Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 109 N. Fremont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Nicholas Goodes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) - 1858

8. AGE: Years	Months	Days	If less than one day
89 88			hr. min.

9. Birthplace Warrenton, N. C. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Rev. James Greene
(b) Address 109 N. Fremont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-16-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Kate R. Williams
(b) Address 323 N. Schroeder St.

19 (a) MAY 16 1947 (Date rec'd by registrar) (b) Huntington, Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/13 1947, at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/6 1947 to 5/13 1947 and that I last saw him alive on 5/13 1947

	Duration
Immediate cause of death	
Due to Cerebral Thrombosis	
Due to Arteriosclerosis	24 yrs
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]
Address 109 N. Fremont Ave. Date signed 5/16/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51763

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G51763

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd & Calvert.

(c) Hospital or institution: Union Memorial Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 month 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1346 W 41st St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Horace Henry Sheffer Dr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-05-4013

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mrs Emma Sheffer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 13-1892

8. AGE: Years	Months	Days	If less than one day
55	2	1	hr. min.

9. Birthplace York Co. Pennsylvania (Town, county, and state)

10. Usual Occupation Sec. & Dental office work

11. Industry or business

FATHER 12. Name Daniel B Sheffer

13. Birthplace Pa

MOTHER 14. Maiden Name Anna Dattisman

15. Birthplace Pa

16 (a) Informant Mrs Emma F Sheffer

(b) Address 1346 W 41 St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 17-1947 (month) (day) (year)

(c) Cemetery or crematory Lorraine Park

Location Baltimore Co. Maryford

18 (a) Funeral director Burgee Funeral Home

(b) Address 3631 Falls Road

19 MAY 16 1947 (Date rec'd by registrar) Registrar Washington Millimore, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-14- 1947, at 1:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-4 1947, to 5-14 1947, and that I last saw h[im] alive on 5-14 1947.

Immediate cause of death	Duration
Myocardial infarction	3 yrs
Due to Coronary occlusion	
Due to H. SH.D	
Other Conditions Pulmonary edema & hypertherax	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Horace Penner M. D.

Address U. M. H. Date signed 5/14/47

VS 150

Theodora Johnson

G51764

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G51764

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1037 N Eutaw St
(c) Hospital or institution
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town, write RURAL and give town)
(d) Street No. 1037 N Eutaw St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theodora Johnson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Negro	Divorced

6 (b) Name of husband or wife Ernest Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 12, 1912

8. AGE: Years	Months	Days	If less than one day
34	5	3	hr. min.

9. Birthplace Warsaw, N. Carolina (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William H. Best
13. Birthplace

MOTHER
14. Maiden Name Sarah E. Bell
15. Birthplace Turkey, N. Carolina

16 (a) Informant Sarah E. Best
(b) Address 1311 Irving St. N.E. Wash. D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 17, 1947 (month) (day) (year)
(c) Cemetery or crematory Harmony
Location Washington, D.C.

18 (a) Funeral director Earl Hilsman
(b) Address 519 Mosher Street

MAY 16 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1947 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 15 1947 to May 13 1947.
and that I last saw him alive on May 13 1947.

Immediate cause of death

	Duration
(a) Lobar Pneumonia	4 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address [illegible] Date signed 5/14/47 M.D.

VS 150

G51765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G51765

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. Please write plainly, with unfading ink. Physicians: please write the correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3901 - 2nd St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3901 - 2nd St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma V. Stansbury

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 21 - 1874

8. AGE: Years	Months	Days	If less than one day
72	4	24	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business Housewife

FATHER
12. Name George F. Weaver
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary E. Creager
15. Birthplace Baltimore

16 (a) Informant Mrs Mollie E. Hoffman
(b) Address 3901 - 2nd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-17-1947 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

19 MAY 16 1947 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 - 1947, at 4-45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/7/47 1947 to 5/14 1947 and that I last saw h[illegible] alive on 5/14 1947.

Immediate cause of death: Coronary Thrombosis Duration 6 hrs

Due to: Senile Myocarditis 2 yrs

Due to: Arterio Sclerosis 2 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Peter Lane

Address 18 - Randall St Date signed 5/16/47

VS 150

G51766

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 112

Registered No. G51766

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1727 Covington St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1727 Covington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine H. Barrett

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anthony H. Barrett
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 21-1891

8. AGE: Years 56 | Months 2 | Days 21 | If less than one day hr. min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Brofany
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Stanley
15. Birthplace Ireland

16 (a) Informant Vincent J. Barrett
(b) Address 1727 Covington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-17-1947 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md.

18 (a) Funeral director Joseph F. Shupe
(b) Address 1416 Light St.

19 MAY 16 1947 (Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14th 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 5 1947 to May 14 1947 and that I last saw h[illegible] alive on May 14 1947

Immediate cause of death	Duration
Cardiac failure	2 days
Pulmonary Edema	1 day
Due to Chronic Bronchial asthma	1937
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter Kohn
Address 1426 Fort Ave. Date signed 5/16/1947 M.D.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

051767 / 92B Registered No. 051762

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3611 Mt. Pleasant St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3611 Mt Pleasant St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Benjamin Crusse

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Widow

6 (b) Name of husband or wife Kate Catherine Lynch 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 17, 1867

8. AGE: Years	Months	Days	If less than one day
77	8	27	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John Crusse
13. Birthplace Md

MOTHER
14. Maiden Name Sharlolf (Elizabeth)
15. Birthplace Md

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/19/47 (month) (day) (year)
(c) Cemetery or crematory Oakland
Location Balto Md

18 (a) Funeral director Harry H. Wilkes
(b) Address 4101 Edmondson Ave

19 (a) MAY 16 1947 Funeral Director Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1947, at 2:50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 14 1947 to May 14 1947 and that I last saw him alive on May 14 1947

Immediate cause of death Gastric ulcer, 10 years — Duration

Due to Arterio-sclerosis — ?

Due to Chronic mitral regurgitation — ?

Other Conditions Coronary thrombosis (Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. Benedict Bronushas, M.D.
Address 3037 O'Donnell St Date signed 5-15-47

VS 190

G51768

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G51768

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital, Balto., Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Maryland (b) County: Baltimore
(c) City or town: Owings Mill
(If outside city or town limits, write RURAL and give town)
(d) Street No.: Caves Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) FULL NAME: John Richard Burroughs

3 (b) If veteran, name war	3 (c) Social Security Account No.
WW II	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife:
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 8, 1915

8. AGE: Years	Months	Days	If less than one day
32	4	7	hr. min.

9. Birthplace: Philadelphia, Pa. (Town, county, and state)
10. Usual Occupation: weather proofer
11. Industry or business:

FATHER
12. Name: George Burroughs
13. Birthplace: ?

MOTHER
14. Maiden Name: Ellen Mc Hale
15. Birthplace: Ireland

16 (a) Informant: Records
(b) Address: US Marine Hospital, Balto., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: May 17-47 (month) (day) (year)
(c) Cemetery or crematory: Balto National
Location: Baltimore Md.

18 (a) Funeral director: Ellsworth Dunagan
(b) Address: 3911 Liberty Heights Ave

19 MAY 16 1947 (Date rec'd by registrar) Christopher Nolan, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 15 19 47 at 5:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 22 19 47 to May 15 19 47 and that I last saw him alive on May 15 19 47

Immediate cause of death: Hepatitis acute, toxic — Duration: 7-10 days

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: accident
(b) Date of occurrence: ? Feb. 8 '47 at ? M
(c) Where did injury occur? Baltimore Co. Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No (Specify type of place)
(e) Means of injury: Fire Explosion of kerosene stove

23. Signature: John L. Lewis, Jr. Asst Surgeon (R)
Address: US Marine Hospital Balto, Md. Date signed: 5/15/47

Howard J. Weddis, M.D.

G51769

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 46E

Registered No. G51769

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3813 Walnut Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3813 Walnut Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence E. Duffy

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Frank L. Duffy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 21st 1889

8. AGE: Years	Months	Days	If less than one day
57	7	22 24	hr. min.

9. Birthplace Delaware
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Frank Messick
13. Birthplace Delaware

MOTHER
14. Maiden Name Susan Rutherford
15. Birthplace Delaware

16 (a) Informant Frank L. Duffy
(b) Address 3813 Walnut Ave

17 (a) Burial (b) Date thereof 5-19-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto. Md.

18 (a) Funeral director Lasuale Funeral Home
(b) Address 7401 Belair Rd.

MAY 17 1947
(Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15th 1947, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 4 1947 to May 15 1947, and that I last saw her alive on May 15 1947.

	Duration
Immediate cause of death Coronary embolism.	½ hr.
Due to carcinoma	6 months.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation April 19, 47
Major findings of operation: Carcinoma of cecum with metastasis.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold H. Burns. M. D.
Address 529 N. Charles St. Date signed 5/19/47

VS 150

C51770 Westheimer

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

117a

Registered No. C51770

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6 33rd. Calvert ST.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Dept. State Wash. D.C.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry C.B. Westheimer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-7-1917.

8. AGE: Years	Months	Days	If less than one day
30	4	12	hr. min.

9. Birthplace New York. (Town, county, and state)

10. Usual Occupation Vice-Consul in Calcutta

11. Industry or business INDIA

FATHER — 12. Name Henry Westheimer.
13. Birthplace New York.

MOTHER — 14. Maiden Name Beulah Adler.
15. Birthplace Baltimore Md.

16 (a) Informant Riverside Mem. Chapel
(b) Address New York.

17 (a) Burial, cremation, or removal (b) Date thereof 5/16/47.
(month) (day) (year)
(c) Cemetery or crematory Ferncliffe
Location Hartsdale, New York

18 (a) Funeral director Riverside Funeral Chapel
(b) Address 1202 Eutaw Place

19 MAY 17 1947 (b) Huntington Williams, M.D.
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-16-47 19 , at 3:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-4 1947 to 5-16 1947 and that I last saw him alive on 5-16 1947.

Immediate cause of death	Duration
Resp. Failure	
Due to	
Due to	
Other Conditions Septic Ulcer.	

(Include pregnancy within 3 months of death)

Date of operation 5-16-47.

Major findings of operation: Septic ulcer.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Murray Kunkel Jr. M. D.
Address Union Mem. Hosp. Date signed 5-16-47.

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51771

Sherbert

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G51771

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 W. Lexington St
(c) Hospital or institution:
Aged Women's & Aged Men's Homes
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 W. Lexington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Delilah Sherbert

3 (b) If veteran, name war: W

3 (c) Social Security Account No. NONE

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Wesley H

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/19/1875

8. AGE: Years 72 | Months 3 | Days 29 | If less than one day hr. min.

9. Birthplace Calvert Co. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name David H. Chambers

13. Birthplace Md.

MOTHER 14. Maiden Name Elizabeth E. Ogden

15. Birthplace Md

16 (a) Informant Mrs. L. H. Reed Supt.

(b) Address 1400 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/19/47 (month) (day) (year)

(c) Cemetery or crematory Marlboro

Location Calvert Co. Md.

18 (a) Funeral director Williams Cook Inc.

(b) Address 1217 St. Paul St.

19 MAY 17 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1947, at 7:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1947, to May 16 1947 and that I last saw her alive on May 13 1947.

Immediate cause of death	Duration
Cardio-Respiratory Failure	
Pulmonary edema	
Due to arteriosclerotic Heart disease, generalized arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maitland Edward Day M. D.

Address 4-E-33-1st-15 Date signed May 16 1947

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51772 Buddecke

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G51772

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 W. Lexington St.
(c) Hospital or institution: Aged Women's - Aged Men's Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 W. Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Douglas Buddecke

3 (b) If veteran, name war: W

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Widowed

6 (b) Name of husband or wife: Buddecke

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 26th 1865

8. AGE: Years	Months	Days	If less than one day
81	5	19	hr. min.

9. Birthplace New Orleans La.
(Town, county, and state)

10. Usual Occupation Inmate

11. Industry or business Home for Aged

FATHER
12. Name Theodore Buddecke
13. Birthplace

MOTHER
14. Maiden Name Julia Marine
15. Birthplace

16 (a) Informant (Mrs) L. H. Read Supt.
(b) Address 1400 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/17/47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

MAY 17 1947 Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15th 1947, at 7.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3rd 1947, to May 15 1947, and that I last saw him alive on May 10 1947.

Immediate cause of death Respiratory Failure + with Cardio-Vascular Collapse

Due to Cerebral Hemorrhage

Due to Generalized arteriosclerotic Cerebro-Cardio-Vascular disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Haviland Edward Day M. D.
Address 4-S-23rd St - 15 Date signed May 16, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

51773

TN. 110455

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

Registered No. 51773

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 908 Wilmont Ct. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John H. Denmead

3 (b) If veteran, name war —

3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Katherine S.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25/ 1859

8. AGE: Years	Months	Days	If less than one day
87	4	20 21	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Robert Denmead

13. Birthplace England

MOTHER

14. Maiden Name Elizabeth ?

15. Birthplace New Jersey

16 (a) Informant Baltimore City Hospitals

(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/19/47 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Eastern Ave. Ext'd

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul St

19 MAY 17 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15th / 1947, at 6:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 6th 1947 to May 15/ 1947 and that I last saw him alive on May 15th 1947

Immediate cause of death Arteriosclerotic CVD. — Duration yrs.

Due to —

Due to —

Other Conditions Old age -

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No Post

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Edgar Beecham M.D.

Address Balto City Hosp Date signed 15 May 47

X

VS 150

G51774

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G51774

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5702 Harford Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Balto
(If outside city or town limits write RURAL and give town)
(d) Street No. 5702 Harford Rd
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME James Arnold

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Married

6 (b) Name of husband or wife Madaline J.

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Mar. 16. 1882

8. AGE:	Years	Months	Days	If less than one day
	62	1	29	hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Barber

11. Industry or business Own Shop

FATHER
12. Name John Arnold
13. Birthplace Germany

MOTHER
14. Maiden Name Fellgin
15. Birthplace Germany

16 (a) Informant Mrs M. J. Arnold
(b) Address 5702 Harf. Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) May 17. 47 (day) (year)

(c) Cemetery or crematory Lakewood
Location Taylor Ave.

18 (a) Funeral director L. Heemann & Son
(b) Address 6067 Harford Rd.

19 MAY 17 1947 (Date rec'd by registrar) Clayton Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15. 1947; at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to May 15 1947, and that I last saw h— alive on May 14 1947.

Immediate cause of death Coronary Thrombosis

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis Krauss M. D.
Address Date signed

VS 2

X

G51775

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G51775

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 30A

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1104 Division St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GRACE COLLINS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex f

5. Color or race c

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Alphonso Collins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1906

8. AGE: Years	Months	Days	If less than one day
40	5	22	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name John Medley.
13. Birthplace Charles Co. Md.

MOTHER
14. Maiden Name Annie Davis.
15. Birthplace Baltimore, Md.

16 (a) Informant Earl Medley
(b) Address 1104 Division St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-17-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto. City

18 (a) Funeral director Wm. F. R. W. Williams
(b) Address 327 N. Schroeder St

19 (a) MAY 17 1947 (Date rec'd by registrar) (b) Tuttle for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/14/47 19 at 2:05 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intracerebral Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D. Medical Examiner.
Date signed 5/15/47

VS 191

G51776

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164c

Registered No. G51776

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 12 Overhill Rd. P.O.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-11
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 12 Overhill Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George C. (GRAFFLIN) Buck

3 (b) If veteran, name war: World War

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: M.

6 (b) Name of husband or wife: Julia N. Cochran

6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Feb 27 1876

8. AGE: Years 71 | Months 2 | Days 18 | If less than one day: hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Pres. Buck Glass Co.

11. Industry or business Glass Mnfr.

FATHER
12. Name Richard B. Buck
13. Birthplace Front Royal Va.

MOTHER
14. Maiden Name Laura E. Graffelin
15. Birthplace Balto. Md

16 (a) Informant Richard B. Buck
(b) Address 12 Overhill Rd -10

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 17 1947 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto Md

18 (a) Funeral director Henry W. Jenkins Sons Co.
(b) Address McCulloh & Eichenlaub Sts.

19 MAY 17 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

I MEDICAL CERTIFICATION

20. DATE OF DEATH 5/15/1947, at 8:40 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Gunshot wound of head.

Due to

Other Conditions Disseminated Carcinomatosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5/15/47 at about 7:40 A.M.
(b) Where did injury occur? 12 Overhill Rd
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury Shot self in left temple

23. Signature C. H. Schleimer M.D.
Medical Examiner.
Date signed 5/15/47

VS 191

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51777

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered G51777

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert.
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DEASCED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5 East 33rd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lee Darby Mahon

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-07-1884

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Mrs. Lee Darby Mahon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-11-1889

8. AGE: Years 58 | Months 1 | Days 5 | If less than one day 2 hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business Lily Tulip Corp.

FATHER 12. Name John B Mahon
13. Birthplace Baltimore, Md

MOTHER 14. Maiden Name Isabella McDonald
15. Birthplace New Brunswick

16 (a) Informant Mrs Lee D Mahon - wife
(b) Address 5 E 33rd St.

17 (a) Cremation (b) Date thereof May 19, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
Balto., Md.

MAY 17 1947

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-16 1947, at 1:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-9 1947, to 5-16 1947, and that I last saw him alive on 5-15 1947.

Immediate cause of death: Myocardial infarction — Duration 4 days

Due to Coronary occlusion

Due to B.S.H.D.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Myocardial infarction

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James McC. Finney M. D.
Address Union Memorial Hosp. Date signed 5-16-47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51778

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93)

Registered No. G51778

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3521 Greenmount Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3521 Greenmount Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES B. SEBASTIAN

3 (b) If veteran, name war: #1 World War
3 (c) Social Security Account No.: no

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Caroline Sebastian
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Oct. 18, 1867

8. AGE: Years 79 | Months 6 | Days 27 | If less than one day hr. min.

9. Birthplace: Felton, Delaware (Town, county, and state)
10. Usual Occupation: Dentist, retired
11. Industry or business: Self

FATHER
12. Name: George M. Bastion
13. Birthplace: Liberty, Penna.

MOTHER
14. Maiden Name: Rachael Brion
15. Birthplace: Liberty, Pa.

16 (a) Informant: friend
(b) Address: Mr. Rob't. N. Hedrick, 1206 W. Belvedere Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/19/47 (month) (day) (year)
(c) Cemetery or crematory: Lorraine Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) MAY 17 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 3rd 1947 to May 15, 1947. and that I last saw him alive on May 15, 1947.

Immediate cause of death: Cerebral Thrombosis. — Duration: 3 days
Due to: Cardio Vascular Hypertensive disease — Duration: 5 yrs.
Due to: — Duration:
Other Conditions: — Duration:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature: George M. Bastion, M.D.
Address 78 W. 25th St. Date signed 5-16-47.

VS 199

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51779

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

106 B

Registered G51779

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3516 Park Hgts. Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3516 Park Hgts. Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET ANN DOWLING

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Walter W. Dowling
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1868

8. AGE: Years	Months	Days	If less than one day
79	0	0	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William L. Stone
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Sarah Reilly
15. Birthplace Balto. Md.

16 (a) Informant Miss Mildred Dowling
(b) Address 3516 Park Hgts. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/17/47 (month) (day) (year)
(c) Cemetery or crematory St. Paul's Cem.
Location Kent Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (c) MAY 17 1947 (Registered by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14, 1947 at 3:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 8 1947 to May 14 1947 and that I last saw h. alive on May 14 1947.

Immediate cause of death	Duration
Pulmonary Hemorrhage	
Due to Bronchiectasis	Several yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis V Blum, M. D. M. D.
Address 2310 Eutaw Pl. Date signed 5/16/47

VS 150

G51780

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

G51780 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 5100 Norwood Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NELSON BAIRD CARRUTHERS

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	212-01-2969

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widow

6 (b) Name of husband or wife Elsie M. Carruthers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 13, 1895

8. AGE: Years	Months	Days	If less than one day
52	1	1	hr. min.

9. Birthplace Bethel, Conn. (Town, county, and state)
10. Usual Occupation Cab Driver
11. Industry or business Greyhound Cab Co.

FATHER
12. Name Robert Carruthers
13. Birthplace England

MOTHER
14. Maiden Name -- Baird
15. Birthplace Scotland

16 (a) Informant Mrs. E. G. Hoskins,
(b) Address P. O. Box 128, Brunswick Md.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/17/47. (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.
19 (a) MAY 17 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14, 1947, at 4:50 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia

Due to

Other Conditions Multiple fractures of ribs, right, fracture of nose

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☒ cause of death, fill in the following: 15/5
(a) Date of injury 5-12-47 at 2:30 A. M.
(b) Where did injury occur? Liberty Heights & Druid Hill Park
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Auto. into pole

23. Signature [signature] Medical Examiner M.D.
Date signed 5-15-47

X

G51781

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G51781

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1817 W. Saratoga St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 30
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1817 W. Saratoga St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME IDA CAROLINE GRAF DRAKE

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 29, 1887

8. AGE: Years	Months	Days	If less than one day
59	7	15	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Clerical Work
11. Industry or business B. & O. R. R. (retired)

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Rev. F. W. Helfer, friend
(b) Address 1800 Penrose Ave.

17 (a) Removal (b) Date thereof 5/17/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Freedom Cem.
Location New Freedom, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAY 17 1947 Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14, 1947, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/12 1947 to 5/14 1947 and that I last saw her alive on 5/14 1947

Immediate cause of death	Duration
Coronary Thrombosis	1 hr.
Due to Arteriosclerotic Cardio-vascular disease	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Helen Laughlin M.D.
Address 400 N. Payson St. Date signed 5/16/47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

051782

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 051782

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1219 Mc Culloh St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1219 Mc Culloh St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lydia B. Simms

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: James L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1902

8. AGE: Years 44 | Months 9 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Robert B. Woods

13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Elizabeth Yates

15. Birthplace Baltimore, Md.

16 (a) Informant Mr. James L. Simms

(b) Address 1219 Mc Culloh St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 17, 1947 (month) (day) (year)

(c) Cemetery or crematory Greatus Mem. Park

Location Baltimore Co. Md.

18 (a) Funeral director Bus. Lawrence H. Stallings

(b) Address 1625 Druid Hill Ave

19 MAY 17 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13, 1947, at 7:45 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1 1947 to 3/13 1947 and that I last saw ____ alive on 3/17 1947

Immediate cause of death: Uremia - Renal — Duration: 13 Days

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. J. Hatchett M.D.

Address 1225 Linden Ave Date signed 5/16/47

G51783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93)

Registered No. G51783

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 530 Gold St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 530 Gold St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Marie Boston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Timothy Boston

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 64 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Westmoreland Co Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Addison Clayton

FATHER 13. Birthplace Westmoreland Co, Va

MOTHER 14. Maiden Name Betty Whiting

MOTHER 15. Birthplace Westmoreland Co Va

16 (a) Informant Timothy Boston

(b) Address 530 Gold St.

17 (a) ✓ (Burial, cremation, or removal) (b) Date thereof 5-18-47 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Balto, Md

18 (a) Funeral director Mrs Leo H Holland

(b) Address 1631 Edmondson Ave

19 (a) MAY 17 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/18/47 19____, at 4:45 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John R Waters M.D. Medical Examiner.

Date signed 5/19/47

G51784

513418

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51B

Registered No. G51784

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 511 Mosher St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dr Owen Parrott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-9-93

8. AGE: Years 53 | Months 9 | Days 6 | If less than one day hr. min.

9. Birthplace N. Ga. (Town, county, and state)

10. Usual Occupation Chiropodist

11. Industry or business

FATHER
12. Name Oliver W. Parrott
13. Birthplace N. Ga.

MOTHER
14. Maiden Name Hermoine Peters
15. Birthplace N. Ga.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address Records.

17 (a) ✓ (Burial, cremation, or removal) (b) Date thereof 5-19-47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Washington, D.C.

18 (a) Funeral director Mrs Geo H. Holland
(b) Address 1631 Druid Hill Ave

19 (a) MAY 17 1947 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1947, at 7.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 12 1947 to May 15 1947, and that I last saw him alive on May 15 1947.

Immediate cause of death Concomatosis — Duration

Due to Carcinoma Probable

Due to

Other Conditions Pleurisy with effusion due to Carcinomatosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy Carcinomatosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Peter L. Scardina M. D.
Address Johns Hopkins Hospital Date signed 5/16/47

G51785

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G51785

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2712 W. Franklin St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 75 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2712 W. Franklin St. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Wilbur King Freeland

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NO

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21, 1871

8. AGE: Years	Months	Days	If less than one day
75	11	24	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Optician
11. Industry or business Retired

FATHER
12. Name John G. Freeland
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie E. King
15. Birthplace Maryland

16 (a) Informant Mr. Wilbur Bowen
(b) Address 2712 W. Franklin Str.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/19/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Md.

18 (a) Funeral director George. W. Little
(b) Address 2700 Edmondson Ave.

MAY 17 1947 (Date received by Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15, 1947 at 10:P M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1946 to May 15 1947. and that I last saw him alive on May 15 1947.

Immediate cause of death Myocardial degeneration and Senility

Duration

Antecedent causes: Morbid conditions, if any, giving rise to the immediate cause, stating the underlying cause last.

Due to Generalized arteriosclerosis

Due to Patient suffered with hypertension several years.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. M. Michel M. D.
Address 2901 Edmondson Ave. Date signed May 16 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51786

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

63c

Registered No. G51786

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 140 S Caroline St
(c) Hospital or institution. ST. JOSEPH'S HOSPITAL
Baltimore Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 16 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore 22
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1831 Portship Road.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Anna D. Smith

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/13/? 1893

8. AGE: Years	Months	Days	If less than one day
54?	3	3	hr. min.

9. Birthplace Baltimore Md.
(Town, county and state)
10. Usual Occupation Home Wife
11. Industry or business

FATHER
12. Name Michael Sulczewski
13. Birthplace Poland

MOTHER
14. Maiden Name Dora ?
15. Birthplace unknown

16 (a) Informant John A Smith
(b) Address 1831 PORTSHIP Road

17 (a) Burial (b) Date thereof 5-18-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore Co. Md

18 (a) Funeral director George A Weber
(b) Address 705 So Dion st

19 (a) MAY 17 1947 Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1947, at 4:38 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 6 1947 to May 16 1947, and that I last saw h alive on May 6th 47.

Immediate cause of death	Duration
Cardio-Respiratory failure.	
Due to Congestive Cardiac failure with	
Due to Hydrothorax, Right pleural cavity and	
Other Conditions unexplained Hypothyroidism	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry T. Wilson, Jr. M. D.
Address St. Joseph's Hospital Date signed 5/16/47

VS 150

110-

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51787

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G51787

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 E. Fort Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 44
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town) 3
(d) Street No. 212 E. Fort Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick E. Gauss

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Mary A. Weber [redacted]
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/4/1871

8. AGE: Years	Months	Days	If less than one day
76	2	11	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Balto. Transit Co.
11. Industry or business Retired

FATHER
12. Name Jacob F. Gauss
13. Birthplace Phila. Pa

MOTHER
14. Maiden Name Catherine Fischer
15. Birthplace Ger.

16 (a) Informant Family
(b) Address 212 E. Fort Ave.

17 (a) B (Burial, cremation, or removal) (b) Date thereof 5/19/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director James L. McCauley
(b) Address 130 E. Fort Ave.

MAY 17 1947 (Date rec'd by Registrar) (c) Transcription for Williams Mills Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/13/47 at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/12/47, to 5/13/47, and that I last saw h. alive on 19

Immediate cause of death	Duration
Coronary thrombosis	5 days
Due to Arteriosclerosis	
Other Conditions Senility	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Isaac Miller M. D.
Address 122 E. Chase Date signed

X 5/14/47

MOREAU

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

51788 — Registered No. C51788

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden + Madison
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 39 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State ~~-~~ (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4009 Southern Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Moreau F Frush

3 (b) If veteran, name war: --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elona M. Frush nee Wilson — 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
about 84			hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wm. Frush
13. Birthplace Balto. Co.

MOTHER
14. Maiden Name Margaret Snyder
15. Birthplace Balto. Co.

16 (a) Informant Mrs. Elona M. Frush
(b) Address 4009 Southern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/19/47 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAY 17 1947 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15th 1947 at 9.30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/6/1947 to 5/15/1947 and that I last saw h[illegible] alive on 5/15/1947

Immediate cause of death	Duration
Respiratory failure	
Due to Right cerebral hemorrhage	39 days.
Due to Adenocarcinoma of ascending colon	
Other Conditions Cachexia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature C. E. Gonzalez, M.D.
Address Maryland General Hospital Date signed 5/15/47.

VS 150

G51789

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V56E

Registered No. G51789

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 DIVISION ST
(c) Hospital or institution: PROVIDENT Hosp. 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 da
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1008 BENNETT Place (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Bessey Woods

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F

5. Color or race Negro

6 (a) Single, married, widowed, or divorced MARRIED

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7 15 1899

8. AGE: Years 47 Months 9 Days 1 If less than one day hr. min. 46 10

9. Birthplace LAUREL MARYLAND (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business —

FATHER
12. Name James A. Hall
13. Birthplace Bayne, Md.

MOTHER
14. Maiden Name Laurel Gardner
15. Birthplace Bennie, Md.

16 (a) Informant Mr. George Ross (SON)
(b) Address Box 305 Laurel, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-18-47 (month) (day) (year)
(c) Cemetery or crematory
Location Laurel, Maryland

18 (a) Funeral director Charles L. Lowe
(b) Address 802 Madison Ave

19 (a) Filed by [illegible] (b) MAY 17 1947 [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1947 at 8:07 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 21 1947 to May 16 1947, and that I last saw her alive on May 16 1947.

Immediate cause of death Uremia — Duration

Due to Papilloma of Bladder with Urinary obstruction

Due to —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. I. B. Higgins / Buford M. D.
Address Provident Hospital Date signed 5-16-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51790

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 44a

G51790 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland + Rayner Ave
(c) Hospital or institution: West Baltimore Gen'l Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Parkville
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3005 Aston Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Kasper

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Eva Kasper
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 27 1906

8. AGE: Years	Months	Days	If less than one day
41	0	19	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Cab Driver
11. Industry or business

FATHER 12. Name ?
13. Birthplace ?

MOTHER 14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Eva M. Kasper
(b) Address 3005 Aston Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/19/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto

18 (a) Funeral director L. J. Luck
(b) Address 5305 Harford Road

19 (a) (Date received by registrar) (b) Huntingtn Williams, M.D.
MAY 19 1947
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-16 1947, at 1:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-15 1947, to 5-16 1947, and that I last saw HIM alive on 5-16 1947

Immediate cause of death: Myocardial Infarction — Duration

Due to Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Berdanier M. D.
Address West Balto Gen'l Hosp Date signed 5-16-47

X

G51791 — Dr. Hirschfeld — 6919 Harford

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 4813

G51791 Registered No.

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3002 Fleetwood Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3002 Fleetwood Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME KATIE J. SACHS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Leonard L. Sachs
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 18, 1883

8. AGE: Years	Months	Days	If less than one day
63	7	29	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Ernest Schroeder
13. Birthplace Germany

MOTHER
14. Maiden Name Augusta ?
15. Birthplace Germany

16 (a) Informant Mr. Leonard L. Sachs
(b) Address 3002 Fleetwood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/20/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 (a) (Date rec'd by registrar) (b) Registrar

MAY 18 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17th 1947, at 12:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/6 1947 to 5/17 1947, and that I last saw HER alive on 5/14 1947

Immediate cause of death: Intraperitoneal Hemorrhage — Duration 4 days
Due to CARCINOMA OF UTERUS with EXTENSIVE METASTASIS — 1 YEAR
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John H. Kirkpatrick M. D.
Address 6919 Harford Rd Date signed 5/17/47

G51792

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G51792 Registered No. 48a

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 43 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits write RURAL and give town)
(d) Street No. 3602 Gibbons Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME IRENE GRISWOLD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 25 1893

8. AGE: Years	Months	Days	If less than one day
53	6	14	hr. min.

9. Birthplace New York
(Town, county, and state)
10. Usual Occupation at Home
11. Industry or business

FATHER
12. Name Frank L. Griswold
13. Birthplace Conn.

MOTHER
14. Maiden Name Lucy M. Woodruff
15. Birthplace Conn.

16 (a) Informant Mr John J. Hughes
(b) Address 3602 Gibbons Ave

17 (a) Burial (b) Date thereof 5/20/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Alderbrook Cem
Location Guilford, Conn.

18 (a) Funeral director L. J. Fusik
(b) Address 5305 Harford Rd.

19 (a) 1947 (b)
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/16 1947, at 5:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/12 1947 to 5/16 1947, and that I last saw her alive on 5/16 1947

Immediate cause of death	Duration
Carcinoma of ovaries and uterus	
Due to Cardiac resp: failure	
Due to Carcinomatosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 4/9
Major findings of operation: Intestinal obstruction, carcinomatosis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. C. Rowley M.D.
Address Univ. Hosp. Date signed 5/16/47

G51793 G51793

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No.

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 CAROLINE ST
(c) Hospital or institution:
ST JOSEPH'S HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County CALVERT
(c) City or town PORT REPUBLIC. MD
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MISS GEORGIANNA MOWBRAY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife NONE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/27/66

8. AGE: Years	Months	Days	If less than one day
80	4	19	hr. min.

9. Birthplace BALTIMORE MD
(Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

MOTHER / FATHER
12. Name ?
13. Birthplace ?
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Nannie Dorsey
(b) Address Port Republic, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 18, 1947 (month) (day) (year)
(c) Cemetery or crematory Christ Church
Location Port Republic, Md

18 (a) Funeral director A. A. Hutchins & Son
(b) Address Mutual, Md (Courtesy of Williams, Md)

19 (a) (Date rec'd by registrar) (b) Registrar

MAY 19 1947

V9-150

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 17 1947; at 5:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-17 1947 to 5-17 1947, and that I last saw h.c.k. alive on 5-16 1947.

Immediate cause of death
BRONCHO PNEUMONIA
TERMINAL
Due to CARDIAC FAILURE
Due to
Other Conditions FRACTURED HIP
(Include pregnancy within 3 months of death)
Date of operation 4-19-47
Major findings of operations FRACTURED HIP
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ACCIDENT
(b) Date of occurrence 4-15 Port Republic ? P.M.
(c) Where did injury occur? HOME CALVERT MD
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? HOME (room) While at work?
(Specify type of place)
(e) Means of injury FALL
23. Signature John B. Wells M.D.
Address St Josephs Hosp Date signed 4-19-47

Released by Med Examiner Wells X

G51794

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G51794
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 226 N. Wolfe St.
(c) Hospital or institution: 6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 4
(If outside city or town limits, write RURAL and give town)
(d) Street No. 226 N. Wolfe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LEGION WATSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Mary Watson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13, 1887

8. AGE: Years	Months	Days	If less than one day
60	-	-	hr. min.

9. Birthplace Farmville Va
(Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER
12. Name unknown
13. Birthplace " "

MOTHER
14. Maiden Name unknown
15. Birthplace " "

16 (a) Informant Margret Cooper
(b) Address 226 N. Wolf St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 17, 47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery cem
Location Brooklyn Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1010 Broadway ave

MAY 18 1947 (Date received by Registrar) (b) City or Town Williamsport Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13, 1947, at 6 P.M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 5-14-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51795

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G51795 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2601 Roslyn Ave.
(c) Hospital or institution: Kenesaw Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1Mo
(e) Length of stay in Baltimore (yrs., mos., or days) 1 Mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State TMd. (b) County Frederick
(c) City or town Frederick
(If outside city or town limits, write RURAL and give town)
(d) Street No. 54 E. Patrick St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Elizabeth Maria C.C. Dixon.

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Louis Frank Dixon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 20th 1880

8. AGE: Years 66 | Months 7 | Days 27 | If less than one day hr. min.

9. Birthplace Frederick, Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George William Cramer
13. Birthplace Frederick Co., Md.

MOTHER
14. Maiden Name Mary Elizabeth Gallion
15. Birthplace Frederick Co., Md.

16 (a) Informant Mr. J. Philip Carty
(b) Address North & Pennsylvania Aves

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 20th 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick, Md.

18 (a) Funeral director Harry E. Carty Co.
(b) Address Frederick Md.

19 (a) (Date received by registrar) Registrar

MAY 18 1947
Vs 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1947, at 3:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 20 1947 to May 17 1947 and that I last saw h-e alive on May 17 1947.

Immediate cause of death: Coronary thrombosis — Duration: 10 hrs.
Due to: Arteriosclerosis — ?
Due to: hypertension — ?
Due to: — 3 mos ?
Other Conditions: Cerebral embolism
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robt. H. Wright M. D.
Address Meares Arts Bldg. Date signed 5/19/47.

Baltimore Md. X

G51796

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G51796 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4304 Penhurst Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4304 Penhurst Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William J. Christopher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Rhoda Margaret Christopher
6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.) December 11, 1865

8. AGE: Years	Months	Days	If less than one day
81	5	5	hr. min.

9. Birthplace near Laurel, Delaware
(Town, county, and state)
10. Usual Occupation Retired - Pennsylvania RR
11. Industry or business Signal Dept.

FATHER
12. Name William Christopher
13. Birthplace Delaware

MOTHER
14. Maiden Name Susan Smith
15. Birthplace Delaware

16 (a) Informant Mr. Wm. J. Christopher
(b) Address 603 Stoneleigh Road

17 (a) Burial (b) Date thereof May 20, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Odd Fellows Cem.
Location Laurel, Delaware

18 (a) Funeral director Miller Lawrence
(b) Address 4510 Liberty Heights Ave.

19 (a) MAY 18 1947 (b) Huntington Millinus M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION 3.45 PM

20. DATE OF DEATH May 16 1947 at 3:47 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1 1947, to May 16 1947, and that I last saw alive on May 14 1947

Immediate cause of death	Duration
Coronary Occlusion	
Due to Arteriosclerosis.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Bernard L. Frankman M.D.
Address 2370 Edmondson Ave. Date signed 5/20/47

VS 188

G51797

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95B

G51797

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address LAFAYETTE AND JOHN
(c) Hospital or institution:
HOSPITAL FOR THE WOMEN OF MARYLAND
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) 3 DAYS

2. USUAL RESIDENCE OF DECEASED:
(a) State DELAWARE (b) County SUSSEX
(c) City or town SELBYVILLE
(If outside city or town limits, write RURAL and give town)
(d) Street No. NONE
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME PEARL — GREEN BERG

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	MARRIED

6 (b) Name of husband or wife WILLIAM GREENBERG
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) 14 DEC 1902

8. AGE: Years	Months	Days	If less than one day
44	5	3	hr. min.

9. Birthplace MILLSBORO SUSSEX DELAWARE
(Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business HOME

FATHER
12. Name ABLE ABLEMAN
13. Birthplace RUSSIA

MOTHER
14. Maiden Name FANNIE BALK
15. Birthplace RUSSIA

16 (a) Informant MAYER ABLEMAN
(b) Address MILLSBORO, DELAWARE

17 (a) Removal (b) Date thereof 5/18/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Beth Emeth
Location Wilmington, Del.

18 (a) Funeral director Harriet Lundeen & Son
(b) Address 1902 Eastern Place

MAY 18 1947 (b) Huntington Williams, M.D.
(Date received by local registrar)

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 May 1947, at 7:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 15 MAY 1947, to 17 MAY 1947, and that I last saw her alive on 17 MAY 1947.

Immediate cause of death PULMONARY EMBOLISM (MULTIPLE) — Duration 2 DAYS

Due to CHRONIC THROMBO PHLEBITIS — 10 YRS

Due to PREGNANCY — 10 YRS 2 DAYS

Other Conditions RHEUMATIC HEART DISEASE - CHRONIC — 5 YRS

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at P.M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Fred Bliss, Jr. M. D.
Address Woman's Hosp. Date signed 17 May 47

G51798

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1134a

G51798 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10a
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4741 Reisterstown Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Allen Raskin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Miriam

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1907

8. AGE: Years 40 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Grocer

11. Industry or business

FATHER 12. Name unknown
13. Birthplace Russia

MOTHER 14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Miriam Raskin
(b) Address 4741 Reisterstown Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-18-47 (month) (day) (year)
(c) Cemetery or crematory Hebrew Young Men
Location Windsor Mill Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 1409 E Balto St

19 (a) MAY 18 1947 Registrar (b) Washington Millians, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1947 at 1:25 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertension C.V. Disease

Due to

Other Conditions Uremia Cerebral Apoplexy Hypertension Heart
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D. Medical Examiner.
Date signed 5-17-47

G51799

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G51799 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1147 Washington Blvd
(c) Hospital or institution: Morrell Park Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1401 W. Fayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Noah Bass

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Bessie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 14-1878

8. AGE: Years 68 | Months 10 | Days 4 | If less than one day hr. min.

9. Birthplace: North Carolina (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name: Wm L. Bass
13. Birthplace: North Carolina

MOTHER — 14. Maiden Name: —
15. Birthplace: —

16 (a) Informant: Kathleen Bass
(b) Address: 1401 W. Fayette St

17 (a) Burial, cremation, or removal: Removal (b) Date thereof: May 18-1947 (month) (day) (year)

(c) Cemetery or crematory
Location: Goldsboro North Carolina

18 (a) Funeral director: Lott & B.M. Walker
(b) Address: Platt Sticker Dr

MAY 18 1947 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1947, at 8 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death: Cardio-Resp. failure — Coma — Duration 48 hrs.

Due to: Diabetis — Years —

Due to

Other Conditions: Arteriosclerotic heart disease — Years —
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Charles Cammack M. D.
Address 910 W. Lombard St Date signed May 19 47.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51800

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

G51800 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette and Calhoun
(c) Hospital or institution:
Franklin Square Hospital W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 117 Gittings St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Fabian

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Margaret V. Fabian
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Dec. 4, 1898

8. AGE: Years	Months	Days	If less than one day
48	6	18 11	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Yard foreman
11. Industry or business B. & O. R. R.

FATHER
12. Name Charles Fabian
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Caldendar
15. Birthplace Md.

16 (a) Informant Margaret V. Fabian
(b) Address 117 Gittings St.

17 (a) Burial (b) Date thereof 5-19-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Anne Arundel County, Md.
18 (a) Funeral director George L. Hohwald
(b) Address 2101 Frederick Ave.
19 (a) (Date rec'd by registrar) MAY 16 1947 (Signature of registrar) Clayton Mitchell

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1947, at 7 40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 29 1947, to May 15 1947, and that I last saw him alive on May 15 1947.

Immediate cause of death Uremia — Duration 17 days
Due to Chronic Glomerulo-nephritis — Duration Unknown
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Stanley B. Klyanovic M.D.
Address Hamil. Sq. Bldg. Date signed 5-16-47

G51801

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G51801

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W Va (b) County
(c) City or town Fairmont
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Married

6 (b) Name of husband or wife Della

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-4-72

8. AGE: Years	Months	Days	If less than one day
75	1	12	hr. min.

9. Birthplace D.C. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Henry Lee
13. Birthplace D.C.

MOTHER
14. Maiden Name Mary ?
15. Birthplace N.C.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Removed (Burial, cremation, or removal) (b) Date thereof May 17 47 (month) (day) (year)
(c) Cemetery or crematory
Location Fairmount W Virginia

18 (a) Funeral director Mrs. Lottie A Elliott, Dft
(b) Address 1129 N. Carlton St

19 (a) MAY 19 1947 (Date received by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1947 at 12 45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 14 1947 to May 16 1947 and that I last saw him alive on May 16 1947

Immediate cause of death	Duration
Anoxia	
Due to Emphysema	?
Due to Bronchial Asthma	45 yrs
	?

Other Conditions Hypertensive heart disease + failure
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Anoxia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Williams M.D.
Address [illegible] Date signed 5/16/47

VS 150

112

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51802

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G51802 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1501 W. Lombard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1501 W. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Crockett Hurst

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W.	Widow

6 (b) Name of husband or wife Late Thomas Hurst
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 28, 1884

8. AGE: Years	Months	Days	If less than one day
62	8	28	hr. min.

9. Birthplace Gwynn Island, Va.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Gilbert Crockett
13. Birthplace Md.

MOTHER 14. Maiden Name Mary Respess
15. Birthplace Va.

16 (a) Informant Thomas H. Clark (nephew)
(b) Address 1821 N. Caroline St.

17 (a) Removal (b) Date thereof May 18/47.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Gwynn Island, Va.

18 (a) Funeral director Harry H. Whitte
(b) Address 4102 Edmondson Ave.

19 (a) MAY 19 1947 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16/47. 19 at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 2 1947 to May 15 1947.
and that I last saw h.r alive on May 15 1947.

	Duration
Immediate cause of death: Coronary Occlusion	1/2 d/47
Due to: Arteriosclerosis	?
Due to:	
Other Conditions: Hypertension	?

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Carl P. Rostberg
Address 326 W Lombard St Date signed 5/17/47

VS 150

X

G51803

AB-108426

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V13B

Registered No. G51803

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3mos 5days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Sykesville (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Virginia Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Ellsworth Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1- 1917

8. AGE: Years	Months	Days	If less than one day
30	3	17	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None.

11. Industry or business

FATHER 12. Name Lee Armsworthy

13. Birthplace Maryland

MOTHER 14. Maiden Name Mary Dafney

15. Birthplace Va.

16 (a) Informant Records-Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-20-47 (month) (day) (year)

(c) Cemetery or crematory Springfield Cemetery

Location Sykesville, Md.

18 (a) Funeral director C. Harry Weer

(b) Address Sykesville, Md.

19 (a) MAY 19 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1947, at 2 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-15 1947, to 5-18 1947, and that I last saw him alive on 5-18 1947.

Immediate cause of death	Duration
Pulmonary Tuberculosis bilateral, far advanced	7 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 5-5-47

Major findings of operation: Above

of autopsy: Above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Maurice M. Lacy, M.D. M. D.

Address Baltimore City Hosp. Date signed 5-18-47

VS 130

X

G51804

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G51804

Bath # 54017 / 157a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 9 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 N. Milton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Schmidt.

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 16. 46

8. AGE: Years 0 | Months 9 | Days -1 | If less than one day - hr. - min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Henry Schmidt
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Kitty Williams
15. Birthplace Baltimore Md

16 (a) Informant Henry Schmidt
(b) Address 1105 N Milton Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 5/21/47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location: Baltimore Md

18 (a) Funeral director Milton Ave Chapel
(b) Address 1217 E. Monument St

19 MAY 19 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17, 1947 at 1 00 p M

21. I certify that death occurred on the date above stated; that I attended deceased from May 6, 1947 to May 17, 1947 and that I last saw him alive on May 17, 1947

Immediate cause of death Hydrocephalus — Duration

Due to Meningitis

Due to H. influenza
Pneumococcus Type 9

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]

Address [illegible] Date signed 5-17-47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51805

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G51805

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 202 W. 29th st
(c) Hospital or institution: 12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 202 W. 29th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William C. Murphy Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of ~~husband~~ or wife Ann Leon Murphy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 28 1888

8. AGE: Years	Months	Days	If less than one day
59	0	18	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Signal Supervisor

11. Industry or business Pa. R. R.

FATHER
12. Name William C. Murphy Sr.
13. Birthplace Ireland

MOTHER
14. Maiden Name Ann B. Dean
15. Birthplace

16 (a) Informant William C. Murphy
(b) Address Seco Apt #2 Rockville Md

17 (a) Burial (b) Date thereof 5/19/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or ~~crematory~~ Woodlawn
Location " Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

MAY 19 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16th 1947, at ? A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/22/47 1940 to 5/15 1947 and that I last saw ~~him~~ alive on 5/15 1947

Immediate cause of death	Duration
Coronary occlusion (recurrent attack)	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas. C. Judd

Address 222 Wendover Rd Date signed 5/17/47

G51806

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G51806

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 207 St. Martins Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 207 St. Martins Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Thomas Burton Ewalt

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-14-5862

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Lillian Walther Ewalt
6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) July 26, 1873

8. AGE: Years	Months	Days	If less than one day
73	9	20	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Banker
11. Industry or business Banking

FATHER
12. Name George Ewalt
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Josephine Smith
15. Birthplace Baltimore, Md.

16 (a) Informant Walther Ewalt
(b) Address 207 St Martins Road

17 (a) Burial (b) Date thereof 5/19/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto. Md.

MAY 19 1947 (b) Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1947, at 8:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 25 1947, to May 16 1947, and that I last saw h[illegible] alive on May 16 1947.

Immediate cause of death	Duration
Cerebral arteriosclerosis	2 mo
Coronary artery disease	7 mo
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Francis W. Gluck M. D.
Address 215 Park Ave Date signed 5/16/47

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G51807 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3626 Kimble Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George J. Summers

3 (b) If veteran, name war: -

3 (c) Social Security Account No. -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widower

6 (b) Name of husband or wife Harriet J. Summers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13, 1849

8. AGE: Years	Months	Days	If less than one day: hr.	min.
77	11	4		8 19

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Furniture Business

FATHER
12. Name Samuel Summers
13. Birthplace Balto.

MOTHER
14. Maiden Name Margaret Frank
15. Birthplace Balto.

16 (a) Informant Mr. George A. Summers
(b) Address 755 Melville Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/20/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAY 19 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-17-47 19... at 9:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-30 1947 to 5-17 1947, and that I last saw him alive on 5-17- 1947

Immediate cause of death	Duration
Uremia	
Congestive Heart failure	
Possible coronary thrombosis	
Due to Arteriosclerotic Vascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Nil
Major findings of operation:
of autopsy: Nil

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury George J. Nassenburg
23. Signature George J. Nassenburg M. D.
Address University Hosp. Date signed 5-17-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

FG51808

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V83a

Registered No. G51808

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Druid St.
(c) Hospital or institution: University Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 708 E. 30th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George A. Rider

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Annie W. Rider
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 27 1880

8. AGE: Years	Months	Days	If less than one day
67	1	18	hr. min.

9. Birthplace A. A. Co., Md.
(Town, county, and state)
10. Usual Occupation Landscape Gardner
11. Industry or business

FATHER
12. Name Abraham Rider
13. Birthplace Elkridge, Md.

MOTHER
14. Maiden Name Margaret Merritt
15. Birthplace A. A. Co.

16 (a) Informant Mrs. Annie M. Rider
(b) Address 708 E. 30th St.

17 (a) Burial (b) Date thereof 5/19/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAY 19 1947 Huntington Williamson, M.D.
(Date Key Received) (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1947 at 6 40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 14 1947 to 15 1947, and that I last saw living alive on May 15 1947.

Immediate cause of death	Duration
(a) Cerebro-vascular accident (Hemorrhage)	
Due to (b) Hypertension	
Due to (c)	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles B. Holmes, M. D.
Address Univ. Hosp. Date signed 6-18-47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51809

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G51809

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3497 Fairview Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3407 Fairview Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert M. Hoblitzell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Helen McFrederick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch. 2, 1881

8. AGE: Years	Months	Days	If less than one day
66	2	13	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation [illegible]
11. Industry or business Retired. R.R.

FATHER
12. Name Rev. S.A.Hoblitzell
13. Birthplace Md.

MOTHER
14. Maiden Name Eleanor V.Follin
15. Birthplace Va.

16 (a) Informant Helen McF.Hoblitzell
(b) Address 3407 Fairview Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof May 19, 47 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Edmondson Ave. &

18 (a) Funeral director John O. Mitchell
(b) Address 1900 Eutaw Place

19 MAY 19 1947 (b) [illegible] Md.
(Date received by registrar) Address

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1947 at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 17 1946, to May 15 1947, and that I last saw h[illegible] alive on May 15 1947.

Immediate cause of death	Duration
Cerebral hemorrhage	6 hrs.
Due to Arterio sclerosis & hyp. ten	Several yrs.
Due to [illegible]	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 2200 Garrison Boulevard Signed 5/17/47

VS 150

G51810

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G51810

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2901 Southern Ave.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2901 Southern Ave. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Alice Stevens Naylor

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: M. Bruce Naylor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 28, 1861

8. AGE: Years 86 | Months 1 | Days 18 19 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name James Stevens
13. Birthplace Baltimore

MOTHER
14. Maiden Name Ellen Harris
15. Birthplace Baltimore

16 (a) Informant Miss Ella Naylor
(b) Address 2901 Southern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/19/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) MAY 19 1947 (Date received by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16, 1947 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1946 to 5/16 1947 and that I last saw her alive on 5/16 19 47

Immediate cause of death Cor Myocardium

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address 5103 Harford Rd. Date signed

VS 150

G51811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G51811

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor Ave. & Dukeland St.
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3104 Sequoia Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Edith Dolgoff

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Louis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April, 1889

8. AGE: Years	Months	Days	If less than one day
58	1		hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Samuel Stein
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Louis Dolgoff
(b) Address 3104 Sequoia Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-19-47 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Mt Carmel

18 (a) Funeral director Jack Lewis Inc
(b) Address 1459 E Balto St

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MAY 19 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18, 1947, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 17, 1947 to May 18, 1947 and that I last saw h.e. alive on May 18, 1947.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Acute pulmonary edema	
Due to Coronary thrombosis	
Other Conditions Diabetes mellitus Hypertension	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leon Toby M.D.
Address West Baltimore Gen. Hosp. Date signed 5/18/47

94a

G51812

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G51812

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2009 McKeen Ave
(c) Hospital or institution 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2009 McKeen Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Effie Groff

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Amos
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years 80 | Months | Days | If less than one day: hr. min.

9. Birthplace Lancaster Co Pa (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Jessie Penn
13. Birthplace

MOTHER 14. Maiden Name Mary Penn
15. Birthplace

16 (a) Informant Oscar Groff
(b) Address 2102 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-20-47 (month) (day) (year)
(c) Cemetery or crematory Fairview Cem.
Location Coatsville Pa

18 (a) Funeral director Jack Lewis, Inc
(b) Address 1429 E Balto St.

MAY 19 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH V-17 1947, at 7:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 30 1947, to May 16 1947, and that I last saw h[illegible] alive on May 16 1947.

	Duration
Immediate cause of death: Cerebral Embolism	16 days
Due to: Chronic Myocarditis	8 yrs.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harris Goldman M. D.
Address 1616 W. North Ave Date signed May 17/47

VS 150

G51813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G51813

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BRAUN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution:
University 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Ft Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 902 Hollins
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stanley Beyer

3 (b) If veteran, name war ?

3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	?

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
64			hr. min.

9. Birthplace Lith.
(Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name ?
13. Birthplace Lith

MOTHER
14. Maiden Name ?
15. Birthplace Lith.

16 (a) Informant Wife Beyer
(b) Address 1406 Virginia Ave Cor Bway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 19 47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director Joseph Casanova
(b) Address 1617 Washington Blvd

19 MAY 19 1947 (Date rec'd by registrar) Washington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-17 1947, at 5:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-17 1947 to 5-17 1947 and that I last saw him alive on 5-17 1947

Immediate cause of death	Duration
Respiratory Failure	
Due to Cardiovascular Disease	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. B. Marshall Jr. M. D.
Address Univ. Hosp Date signed 5-19-47
For J. H. Davis, by Howard J. Worthington, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓107

Registered No. G51814

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 21 N. Caroline St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Graves

3 (b) If veteran, name war: WWI
3 (c) Social Security Account No.:

4. Sex: M
5. Color or race: col
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Marie Brown Graves
6 (c) If alive, give age: 55 years
7. Birth date of deceased (mo., day, yr.): ?
8. AGE: Years: ? 56 Months: ? Days: ? If less than one day: hr. min.
9. Birthplace: Orange County, Va. (Town, county, and state)
10. Usual Occupation: Home
11. Industry or business:

FATHER
12. Name: ?
13. Birthplace: ?

MOTHER
14. Maiden Name: ?
15. Birthplace: ?

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: May 19, 1947 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Nat
Location:

18 (a) Funeral director: Clary O. Wilson
(b) Address: 10 E Blantley Ave

19 (a) MAY 19 1947 (Date received by registrar) (b) Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1947, at 9:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 7 1947 to May 14 1947 and that I last saw him alive on May 14 1947

Immediate cause of death: Subdural hematoma — Duration: 8 days

Due to: undetermined

Due to:

Other Conditions: Bronchopneumonia right lung — 2 days
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: John L. Lewis, Jr. Asst. Surgeon (a)
Address: US Marine Hospital Baltimore, Md. Date signed: 5/15/47

VS 150

F3a

BALTIMORE CITY HEALTH DEPARTMENT

G51815 BC# 087918 CERTIFICATE OF DEATH ✓1600 Registered No. G51815

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 904 Drill Court -25-
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Zone 25
(c) City or town Balto Md 904 Drill Court
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? and: (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Robert Weber

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17th 47

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name John Weber
13. Birthplace N. Y.

MOTHER 14. Maiden Name Mary Williams
15. Birthplace Scranton Penn.

16 (a) Informant Mrs Patric Joyce
(b) Address Scranton Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 19-47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem.
Location Gov. Ritchie Highway Cimetery

18 (a) Funeral director Milton Schilling -
(b) Address 3946 Hanover St

19 MAY 19 1947 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17th 1947, at 11.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 17 1947 to May 17 1947, and that I last saw h[illegible] alive on May 17 1947

Immediate cause of death	Duration
cerebral hemorrhage	
Due to	
Due to	
Other Conditions partial atelectasis. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip W. Kuster M.D.
Address 302 Patapsco Ave Date signed May 18 47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓1200

Registered No. G51816

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address West Baltimore General Hospital
(c) Hospital or institution: Dukeland & Mayner Ave 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3811 Bateman Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CUTLER, FAYE Ray ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Albert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18, 1914

8. AGE: Years	Months	Days	If less than one day
33	0	6	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business House Work

FATHER
12. Name Solomon Borshay
13. Birthplace Russia

MOTHER
14. Maiden Name Sonia Rubin
15. Birthplace Russia

16 (a) Informant Louis Borshay
(b) Address 3606 Reisterstown Road

17 (a) Burial (b) Date thereof May 19, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros ve
(b) Address 1124-1126 W North Ave

19 (a) May 19 1947 Huntington Williams, M.D. Address

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1947 at 8:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1947 to May 18 1947 and that I last saw her alive on May 18 1947

Immediate cause of death: Hyper-pyrexia — Duration: 3 days

Due to: Toxemia — 3 days

Due to: gastro-enteritis infection of unknown etiology — 1 week

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leopold E. Blumenthal M.D.
Address WBJH Date signed 5/18/47

X

G51817

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G51817

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3132 Stafford St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3132 Stafford St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Bernard McDowell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary J. McDowell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 4 1874

8. AGE: Years	Months	Days	If less than one day
72	7	13	hr. min.

9. Birthplace Washington D.C.
(Town, county, and state)
10. Usual Occupation Retired Assembler
11. Industry or business Monitor Controller Co

FATHER
12. Name Joseph A McDowell
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mary J. McDowell
(b) Address 3132 Stafford St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 20 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore Md

18 (a) Funeral director Harry A Ammann
(b) Address 4204 Ridgewood Ave

19 MAY 19 1947 (b) Washington Williams M.D.

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17, 1947 1947 at 12:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1943 to May 17 1947 and that I last saw h. alive on May 14 1947

Immediate cause of death	Duration
Aortic sclerotic heart	3 years
Due to Uraemia	
Due to	
Other Conditions Left hemiplegia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J M Collins
Address 332 Frederick Date signed 5/19/47 M D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51818

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G51818

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1100 N. Eutaw Place
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 1100 N. Eutaw Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Behrends

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 10 1880

8. AGE: Years 66 | Months 6 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER 12. Name August Behrends
13. Birthplace Germany

MOTHER 14. Maiden Name Catherine E—
15. Birthplace Germany

16 (a) Informant Marie A Kerby
(b) Address 1101 N. Eutaw St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 20 1947 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Harry H. Womacock
(b) Address 4204 Reisterstown Ave

19 (Date rec'd by registrar) MAY 19 1947 Washington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/17/47 19, at 9:00 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D. Medical Examiner.
Date signed 5/18/47

G51819 Masely

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G51819

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1451 Parrish St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1451 Parrish st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME TEACOBOY GILLIAM.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. ?

6 (b) Name of husband or wife ?

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 5-8-1894

8. AGE: Years 53 | Months | Days 9 | If less than one day hr. min.

9. Birthplace South Carolina
(Town, county, and state)

10. Usual Occupation House Work

11. Industry or business

FATHER 12. Name John Wilson
13. Birthplace S.C.

MOTHER 14. Maiden Name Alice Henderson
15. Birthplace S.C.

16 (a) Informant Lucilly Price
(b) Address 1451 Parrish St

17 (a) Shipped (b) Date thereof 5-19-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory MOUNT AUBURN Cem
Location BALTIMORE MARYLAND

18 (a) Funeral director William A Jackson
(b) Address 916 Penna ave

19 (a) MAY 19 1947 (b)
(Date rec'd by registrar) (Huntington Williams, M.D.)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1947, at 9-4 M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 16 1947 to May 17 1947 and that I last saw her alive on May 17 1947.

Immediate cause of death	Duration
Arteriosclerotic Heart disease	2
Due to Generalized Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stephen H. Moseley Jr M. D.
Address 2024 Madison Ave Date signed 5/20/47

VS 150

FG51820 515313 Bk 11057

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 181

Registered No. G51820

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1617 Bank St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Paul DiNardo

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-27-44

8. AGE: Years 2 | Months 7 | Days 20 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Philip DiNardo
13. Birthplace md.

MOTHER
14. Maiden Name Marion Doherty
15. Birthplace md

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address Record.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-20-47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem.
Location German Hill Rd.

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. Wolfe St.

19 MAY 19 1947 (Date received by registrar) Huntington Williams

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH May 17 1947, at 6.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 14 1947 to May 17 1947 and that I last saw him alive on May 17 1947.

Immediate cause of death CARDIAC FAILURE Duration

Due to Secondary to burns

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 3/1
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 5-14-47 at 3 P. M.
(c) Where did injury occur? 1617 Bank St (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? no
(e) Means of injury Fell into pot of hot water

23. Signature Barton Child M.D.
Address Johns Hopkins Hosp Date signed 5-18-47
For Dr. J.R. Davis, by Howard F. Madeira, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51821

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G51821

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5279 W. Mount St.
(c) Hospital or institution: 19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 527 W. Mount St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Hattler

3 (b) If veteran, name war

5 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 6, 1908

8. AGE: Years	Months	Days	If less than one day
38	9	9	hr. min.

9. Birthplace Apex N.C (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name William Hattley
13. Birthplace Apex N.C

MOTHER
14. Maiden Name Elodie
15. Birthplace Apex N.C

16 (a) Informant Bridget Hattley
(b) Address 2344 W. Gilmore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 19 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 A Schroeder St

19 (a) MAY 19 1947 (Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 15, 1947, at 4.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from MAY 15 1947 to 19; and that I last saw HIM alive on MAY 15 1947.

Immediate cause of death	Duration
CORONARY HEART DISEASE	UNKNOWN
Due to UNKNOWN	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas W. Harris, Jr. M. D.
Address 1824 W. Franklin St Date signed 5-16-47

VS 150

X

G51822

514610.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/31a

G51822 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 832 N Strickar St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert Lawston

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Black	M

6 (b) Name of husband or wife Pearl
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) 2-23-00

8. AGE: Years	Months	Days	If less than one day
47.	2	21	hr. min.

9. Birthplace N.C.
(Town, county, and state)
10. Usual Occupation Both. Steel.
11. Industry or business

FATHER
12. Name George Lawston
13. Birthplace N.C.

MOTHER
14. Maiden Name Lassie Smith
15. Birthplace N.C.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 19 1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St
MAY 19 1947 (Date rec'd by Registrar) (b) Huntington Williams Mgr. Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH May 16 1947, at 2.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 2 1947, to May 16 1947, and that I last saw him alive on May 16 1947.

Immediate cause of death	Duration
Uremia	1 mo
Due to Chronic glomerulo-nephritis	2 yrs?
Due to	
Other Conditions Hypertension Cardio vascular disease	2 yrs?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Post mort

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [illegible] M.D.
Address [illegible] Date signed 5/16/47

VS 150

X

G51823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

G51823 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division
(c) Hospital or institution: Provident Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 D
(e) Length of stay in Baltimore (yrs., mos., or days) 54Y

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2637 Puget (Puget)
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Marion

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Negro	Married

6 (b) Name of husband or wife Emma Marion
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18, 1908

8. AGE: Years	Months	Days	If less than one day
39	11	28	hr. min.

9. Birthplace Sumpter S.C.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name George Marion
13. Birthplace Sumpter, S.C.

MOTHER
14. Maiden Name Frances Davis
15. Birthplace Sumpter

16 (a) Informant Emma Marion
(b) Address 2637 Puget ST

17 (a) Burial (b) Date thereof 5-19-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lincoln
Location Lincoln Cemetery

18 (a) Funeral director Mrs Katie R. Williams Schoolcraft
(b) Address 3223

19 (c) MAY 19 1947 (d) Huntington Williams Mgr
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1947 at 7.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 7 1947 to May 15 1947 and that I last saw him alive on May 15 1947.

Immediate cause of death	Duration
Generalized Peritonitis	
Due to Ruptured Appendix	
Due to	
Other Conditions Paralytic Ileus	

(Include pregnancy within 3 months of death)
Date of operation May 7 1947
Major findings of operation: Ruptured Appendix & retrocecal abscess
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. L. Jackson M. D.
Address Provident Hosp Date signed 5-15-47

X

G51824

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G51824 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 225 Jasper st.
(c) Hospital or institution: 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 225 Jasper
(If rural give location)
(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME David Jones

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-09-5462

4. Sex: male | 5. Color or race: colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) april 9, 1910

8. AGE: Years 37 | Months 1 | Days 8 | If less than one day — hr. — min.

9. Birthplace Nottoway Co, Va
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Bethlehem steel Co

FATHER
12. Name Simon Jones
13. Birthplace Nottoway Co. Va

MOTHER
14. Maiden Name Marie Bell
15. Birthplace Nottoway Co. Va

16 (a) Informant Frederick Jones
(b) Address 781 W. Saratoga St

17 (a) [illegible] (Burial, cremation, or removal) (b) Date thereof 5-20-1947 (month) (day) (year)

(c) Cemetery or crematory
Location Blackstone Virginia

18 (a) Funeral director Mrs Katie R. Williams
MAY 19 1947 A. Schindler
(Date rec'd by registrar)

19 (a) (b) Thurlington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5.17.47 19 at 10:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5.15.47 19 to 5.17.47 19, and that I last saw him alive on 5.16.47 19.

Immediate cause of death Congestive heart failure — Duration few hrs.

Due to Cardio renal vascular Disease — ?

Due to —

Other Conditions Bronchial asthma — ?

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence —
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature James M. Fair M.D.
Address 400 N. Carrollton Date signed 5-19-47

VS 3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

651825

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 651825

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) since 3/12/47
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2 N. Carey St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Williams

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife Hattie Holland
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 6, 1877

8. AGE: Years	Months	Days	If less than one day
70	3	9	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Janitor
11. Industry or business

FATHER
12. Name Charles Williams
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Nellie Joyce
15. Birthplace Howard Co. Md.

16 (a) Informant Thelma Cox
(b) Address 843 N. Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-19-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location

18 (a) Funeral director Mrs K R Watkins
(b) Address 322 N. Schroeder St.

19 (a) MAY 19 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/15 1947, at 9 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular disease

Due to

Other Conditions Cellulitis of both Legs
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. P. Johnson M.D.
Medical Examiner.
Date signed 5/16/47

VS 151

G51826 AC# D 79017

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G51826

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton + Wilkens Aves
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 hrs. 9 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 27 hrs. 9 min.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5216 Old Frederick Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Irvin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, ~~married, widowed, or divorced~~: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/17/47

8. AGE: Years | Months | Days: 1 | If less than one day: 27 hr. 9 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Maurice L. Irvin
13. Birthplace

MOTHER — 14. Maiden Name Beatrice Lorenz
15. Birthplace Md.

16 (a) Informant Maurice Irvin
(b) Address Catonsville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 19 47 (month) (day) (year)
(c) Cemetery or crematory Oakland ME Ch
Location Carroll Co

18 (a) Funeral director Edgar S. MacNabb
(b) Address Catonsville, Md

19 (a) MAY 19 1947 (b) Registrar's signature Williams, M.D.

US 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/18 1947, at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/17 1947 to 5/18 1947, and that I last saw him alive on 5/18 1947.

	Duration
Immediate cause of death: Respiratory failure	
Due to: Cause ?	
Due to:	
Other Conditions: Premature — 6½ months — 3 lbs 2 oz	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert L. Landau, M.D.
Address 5216 Old Frederick Rd. Date signed 5/18/47

G51827

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

O.C.# F90204 / 115c

Registered No. G51827

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~Res.~~ 2025 W. Fayette St
(c) Hospital or institution: Bon Secours Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1318 N. MONTFORD AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RICHARD LASSAHN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) (Single), married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/2/44 12/2/44

8. AGE: Years	Months	Days	If less than one day
2	5	15	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Ernest H. Lassahn, Jr.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Ruth M. Hannewald
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. John L. Hannewald
(b) Address 4808 Anntana Ave.

17 (a) burial (b) Date thereof May 20th/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Parkwood
Location Taylor Ave.

18 (a) Funeral director Leo A. Lahn Funeral Home
(b) Address 7401 Belair Road

19 (c) MAY 19 1947 [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 17 1947, at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from MAY 17 1947 to MAY 17 1947, and that I last saw him alive on MAY 17 1947.

Immediate cause of death	Duration
3. Cerebral anoxemia	
Due to Phelps - pharyngitis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. H. Lassahn Jr.
Address Bon Secours Hosp. Date signed 5/19/47

C51828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

Registered No. C51828

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 733 McCabe Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Edward Kates

3 (b) If veteran, name war ?

3 (c) Social Security Account No. 214-20-0810

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Mrs. Gena F. Kates
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 12, 1888

8. AGE: Years	Months	Days	If less than one day
58	6	6?	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business Western Electric

FATHER
12. Name Henry Joseph Kates
13. Birthplace Maryland.

MOTHER
14. Maiden Name Henrietta Fuld
15. Birthplace Maryland

16 (a) Informant Hospital Records.
(b) Address Union Memorial Hosp.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/21/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Harford Rd.

18 (a) Funeral director Edward Faulson
(b) Address 2359 Wash Blvd.

19 MAY 19 1947 Registrar

VS 150

MEDICAL CERTIFICATION

DATE OF DEATH May 18 1947, at 5:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 4 1947 to May 18 1947 and that I last saw him/her alive on May 18 1947.

Immediate cause of death	Duration
1 Pulmonary hemorrhage	few minutes
Due to Carcinoma of lung	at least 2 mths
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation May 14, 1947
Major findings of operation: Inoperable Carcinoma of left lung.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ernest V. deMoss M. D.
Address Union Memorial Hospital Date signed 5-18-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

G51829 Dth # 19643 CERTIFICATE OF DEATH 159 Registered No. G51829

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 932 N. Washington (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Hill

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5 17 47

8. AGE: Years	Months	Days	If less than one day
			7 hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER — 12. Name Everette Hill
13. Birthplace Baltimore

MOTHER — 14. Maiden Name Daisy Hamilton
15. Birthplace Baltimore

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 19, 1947 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Anne Arundel Co.

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2005 Gilmore St.

19 MAY 19 1947 (Date rec'd by registrar) (c) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1947 at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 17 1947 to May 17 1947 and that I last saw h alive on May 17 1947.

Immediate cause of death	Duration
Abruptio placentae	
Due to Premature birth (wt. 5 lbs 10 oz)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D D Griggs M. D.
Address Johns Hopkins Hospital Date signed 5-17-47

VS 150

G51830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G51830

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Mem. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50+ yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3722 Foster ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. George W. Wagner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	widowed

6 (b) Name of husband or wife Mrs. Georgie W. Wagner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 17, 1885

8. AGE: Years	Months	Days	If less than one day
61	9	0	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation odd jobs
11. Industry or business

FATHER
12. Name Jeremiah Wagner
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Grimmell
15. Birthplace Maryland

16 (a) Informant Mrs. Carl Dochterman
(b) Address Middle River Box 202

17 (a) Burial Rapid Falls (Burial, cremation, or removal) (b) Date thereof 5/20/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2060 Orleans St

19 (a) MAY 19 1947 (Date rec'd by registrar) (b) Huntington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1947 at 6:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1947 to May 17 1947 and that I last saw h[illegible] alive on May 17 1947

Immediate cause of death	Duration
Cerebral Hemorrhage	3 Days
Due to hypertensive vascular disease	7
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Cerebral hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. W. Shaw M. D.
Address Union Mem. Date signed 5/11/47

VS 150

Hosp X

G51831

A5049

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 160a

Registered No. G51831

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Harford
(a) State Md. (b) County A. A.
(c) City or town Aberdeen Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. ~~Ford Corner Mart~~
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Ochman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-10-47

8. AGE: Years	Months	Days	If less than one day
		8	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Stanley R. Ochman
13. Birthplace Wilkes-Barre Pa.

MOTHER — 14. Maiden Name Jeannie A. Rutherford
15. Birthplace Wilkes-Barre, Pa.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/20/47 (month) (day) (year)
(c) Cemetery or crematory Post Cemetery
Location Fort George G. Meade Md.

18 (a) Funeral director Howard M. Blight Jr.
(b) Address 4914 Belair Road

MAY 19 1947 (b) Huntington Williams, M.D.
(Deputy Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May-18 1947, at 3:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-13- 1947 to 5-18- 1947, and that I last saw her alive on 5-18- 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Prematurity	
Due to	
Other Conditions Intracranial Hemorrhage	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Barton Childs
Address Johns Hopkins Hosp. Date signed 5-21-47

VS 150

G51832

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G51832

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2015 Madison Ave.
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2015 Madison Ave. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Caesar Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10, 1893

8. AGE: Years	Months	Days	If less than one day
54	2	4	hr. min.

9. Birthplace Gloucester Co. Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Caesar Jackson
13. Birthplace Virginia

MOTHER
14. Maiden Name Martha Ross
15. Birthplace Virginia

16 (a) Informant Henry Jackson
(b) Address 2015 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 16, 1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Lee H. Stallcup
(b) Address 1631 Druid Hill Ave.

19 MAY 19 1947 [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1947 at 6:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 14 1947 to May 14 1947 and that I last saw h[illegible] alive on May 14 1947

	Duration
Immediate cause of death Coronary Disease of Heart	3 hrs
Due to hypocarditis	9 mos
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John E. S. Campen M. D.
Address 639 N. Carey Date signed 5-17-47

G51833

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G51833

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 14 POULTNEY ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE MD
(If outside city or town limits, write RURAL and give town)
(d) Street No. 14 POULTNEY ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET M. SCHLEICH.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex FEM | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced WIDOW

6 (b) Name of husband or wife FREDERICK SCHLEICH

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) APRIL 13 1872

8. AGE: Years 75 | Months 1 | Days 3 | If less than one day hr. min.

9. Birthplace BALTIMORE MD (Town, county, and state)

10. Usual Occupation HOUSE WORK.

11. Industry or business AT HOME

FATHER
12. Name NOT KNOWN
13. Birthplace NOT KNOWN

MOTHER
14. Maiden Name NOT KNOWN.
15. Birthplace NOT KNOWN

16 (a) Informant ALBERT SCHLEICH.
(b) Address 14 POULTNEY ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAY 20 47 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BALTIMORE MD

18 (a) Funeral director Bernard C Hahn
(b) Address 121 E West St

19 Date received MAY 19 1947 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 16 1947 at 5.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 3 1946 to May 16 1947.
and that I last saw her alive on 5-16-47 19
Immediate cause of death Pneumonia
Due to Bronchial pneumonia.
Due to Advanced Arteriosclerosis.
Other Conditions

Duration: 1 Year

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature H. Faught MD M. D.
Address 642 Wash. Blvd Date signed 5-16-47

VS 150

G51834

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 183 G51834

Registered No.

Found in harbor-Pier #16 Light St.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Norfolk,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 410 Walker Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CURLEY WILSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15, 1897

8. AGE: Years 50 | Months 2 | Days 1 | If less than one day hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Fireman

11. Industry or business Merchant Marine

FATHER
12. Name Charles Wilson
13. Birthplace Virginia

MOTHER
14. Maiden Name Maggie ?
15. Birthplace Virginia

16 (a) Informant James Wilson, Va.
(b) Address 1428 W. 42nd Street Norfolk, Virginia

17 (a) Burial (b) Date thereof 5 19 47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem.
Location Balto. County

18 (a) Funeral director Mrs. Mt. Elliott Daughtry
(b) Address 1127 N. Carolina Ave.

19 (a) (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

MAY 19 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16, 1947, at 7.50 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☒ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 23/3

(a) Date of injury Found: May 16, 1947 7 A. M.
(b) Where did injury occur? Found Harbor--Pier #16--Light Street
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Found Drowned

23. Signature Earl L. Ryer M.D.
Medical Examiner.
Date signed 5/19/47

G51835

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G51835
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dist
(c) Hospital or institution: South Balto General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1028 Peach Alley
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Artie Sellers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years	Months	Days	If less than one day
42			hr. min.

9. Birthplace Ellerslie Ga.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Horace Sellers
13. Birthplace Ellerslie Ga

MOTHER
14. Maiden Name Mary Oliver
15. Birthplace Ellerslie Ga.

16 (a) Informant Floyd Sellers
(b) Address 1402 W. Saratoga St

17 (a) Burial (b) Date thereof 5/22/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. Co. Md.

18 (a) Funeral director Metropolitan Funeral Home
(b) Address 907 N. Mt. Mosier St

(a) 5-19-1947 (b) Huntington Williams Inc.
(Date rec'd by registrar)

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MEDICAL CERTIFICATION

20. DATE OF DEATH 5/18 1947, at 7:25 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature R. S. Leibowitz M.D.
Medical Examiner.
Date signed 5/19/47

X

G51836 BEM

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G51836

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4101 Parkwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Beese

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife No Husband

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12 1862

8. AGE: Years 84 Months 8 Days 5 If less than one day hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/20/47 (month) (day) (year)
(c) Cemetery or crematory Oak Hill Cemetery
Location Homers Lane

18 (a) Funeral director Howard N. Bight Jr.
(b) Address 4914 Belair Road

19 (a) MAY 19 1947 (Date received by Registrar) (b) [illegible] Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1947 at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1947 to May 17 1947 and that I last saw him alive on May 17 1947

Immediate cause of death	Duration
Cerebral Hemorrhage	5 days
Due to	
Due to Arteriosclerosis	5 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M.D.
Address 1631 E North Ave Date signed 5/16/47

X

G51837 HEALTH DEPARTMENT—CITY OF BALTIMORE G51837

CERTIFICATE OF DEATH V 46 B

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3112 Taylor Ave. St. 16 Ward)

Length of residence in city or town where death occurred ...yrs.....mos. 7 ds. How long in U. S. If of foreign birth? ...yrs.....mos.....ds.

2. FULL NAME LULA E. WILSON

If U.S. Veteran specify WAR .....

(a) Residence: No. 3112 TAYLOR AVE St., ... Ward. .....
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
female	white	widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: George W. Wilson

6. DATE OF BIRTH (month, day, year): March 30, 1880

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
67	1	16 17	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.:

10. Date deceased last worked at this occupation (month and year):

11. Total time (years) spent in this occupation:

12. BIRTHPLACE (city or town) (State or country): Wilmington, Del.

FATHER

13. NAME: Elizah K. Thompson

14. BIRTHPLACE (city or town) (State or country): Del.

MOTHER

15. MAIDEN NAME: Mary Scheppenhezer

16. BIRTHPLACE (city or town) (State or country): Pa.

17. INFORMANT: Mrs. Emily W. Gail

(Address): 3112 Taylor Ave.

18. BURIAL, CREMATION, OR REMOVAL

Place: Parkwood Date: 5/20/47 19...

19. UNDERTAKER: WM. J. TICKNER & SONS

(Address): Balto. Md.

20. MAY 19 1947 [illegible] Williams, M.D. Registrar.

VS 3

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year): May 16, 1947

22. I HEREBY CERTIFY, That I attended deceased from MAY 1, 19 47 to MAY 16, 19 47

I last saw her alive on 5/16, 19 47 Death is said to have occurred on the date stated above, at 8 35 PM

The principal cause of death and related causes of importance were as follows:

	Date of onset
CA. STOM	1 yr prior 5/47.
CARDIAC FAILURE	
Other contributory causes of importance:	

Was an operation performed? YES Date of SEPT 1946

For what disease or injury? CA STOM.

What test confirmed diagnosis? Path Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19.....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased?

If so, specify .....

(Signed) Walter E. Kenyon M.D.

(Address) 4331 Hayfield Rd

G51838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G51838

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and name town)
(d) Street No. 354 Herring Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edmund Edward J. Szelongowske (SZELONGOWSKI)

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No.: none

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1947, at 10 A.M.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife: Catherine Szelongowski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1895

8. AGE: Years	Months	Days	If less than one day
52	4	16	hr. min.

9. Birthplace: Poland (Town, county, and state)
10. Usual Occupation: Retired Baker
11. Industry or business: Perry Point

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden Name: Unknown
15. Birthplace: "

16 (a) Informant: Mrs. Catherine Szelongowski
(b) Address: 354 Herring Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/20/47 (month) (day) (year)
(c) Cemetery or crematory: Balto. Nat'l. Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 MAY 19 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

21. I certify that I took charge of the remains described above, held an Aut & Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Coronary occlusion

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Helfrich M.D. Medical Examiner.
Date signed May 17, 1947

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G51839

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G51839 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 614 Wyanoke Ave.
(c) Hospital or institution: 9th
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 614 Wyanoke Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LAURA B. GRIM

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Francis M. Grim
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec. 18, 1864

8. AGE: Years 82 | Months 4 | Days 28 | If less than one day hr. min.

9. Birthplace: Liberty, Ind.
(Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: Daniel Toomey
13. Birthplace: Md.

MOTHER
14. Maiden Name: Rachel Yeager
15. Birthplace: Md.

16 (a) Informant: Miss Laura B. Grim
(b) Address: 614 Wyanoke Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/19/47 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 MAY 19 1947 (Date received by registrar) [signature]

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16, 1947 at 11:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 10 1940 to May 14 1947, and that I last saw h[illegible] alive on May 12 1947.

Immediate cause of death	Duration
(a) Chron. Myocarditis	1940
(b) Chron. Interstitial Nephritis	1940
Due to (c) Arteriosclerosis	1940
Due to	
Other Conditions Arter. Coron. Sclerosis	1947

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. W. Bushy M. D.
Address 507 Cherlew Ave. Date signed 5/16/47

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G51840

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G51840 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 208 Harmison St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 208 Harmison St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: MARTHA M. KIRSCH

3 (b) If veteran, name war: -
3 (c) Social Security Account No. -

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Charles Kirsch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec. 1, 1882

8. AGE: Years: 64 | Months: 5 | Days: 17 | If less than one day: hr. min.

9. Birthplace: Germany
(Town, county, and state)

10. Usual Occupation:
11. Industry or business:

FATHER
12. Name: Carl Goette
13. Birthplace: Germany

MOTHER
14. Maiden Name: Anna Newbauer
15. Birthplace: Germany

16 (a) Informant: Mr. C. L. Richwien
(b) Address: 208 Harmison St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/21/47 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 MAY 19 1947 (Date rec'd by reg.) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 18 1947 at 4:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1942 to May 18 1947.
and that I last saw h. alive on 5/18 1947.

Immediate cause of death: Uremia — Duration: 2 Months
Due to: Cardio-Vascular Disease & Hypertension — 5 Years
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Elliott W. Johnson M.D.
Address 3432 Frederick Ave. (Date signed) 5/18/47

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

Registered No. G51811

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W 40th St
(c) Hospital or institution: Home for Incurables 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr 3 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs 3 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. 6
(If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W 40th St
(If rural give location)
(e) Citizen of foreign country? Of U S A (Yes or No)
If yes, name country

3 (a) FULL NAME Opdyke, Mrs Susan Elizabeth

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	W.

6 (b) Name of husband or wife Stanford Opdyke
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 23, 1875

8. AGE: Years	Months	Days	If less than one day
72	2	25	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

MOTHER / FATHER
12. Name Henry Reuther
13. Birthplace Balto. Md
14. Maiden Name Susan Zollickoffer
15. Birthplace Virginia (Winchester)

16 (a) Informant Executor
(b) Address Home for Incurable, Reards.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/20/47 (month) (day) (year)
(c) Cemetery or crematory Govans Presby. Cem.
Location Govans, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 MAY 19 1947 (Date rec'd by local registrar) Huntington Williams, M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1947, at 10:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 18 1946, to May 18 1946, and that I last saw her alive on May 17 1946.

Immediate cause of death	Duration
Congestive Heart Failure	10 days
Due to Coronary Thrombosis	7 weeks
Due to Hypertension and Arterial Cardio Vasc. Disease	Many years
Other Conditions Arthritis Deformans	Many years

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas Conant Wolf, M. D.
Address 11 E. Chase St. Date signed 5/18/47
Baltimore 2, Maryland

G51842

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83

Registered G51842

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3404 Duvall Ave
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3404 Duvall Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Grafton Johnson

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Helen Witherspoon
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) July 27, 1881

8. AGE: Years	Months	Days	If less than one day
66	9	21 22	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Clerical
11. Industry or business Library (Pratt)

FATHER
12. Name Grafton Hollis Johnson
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Ellen Augusta Harrington
15. Birthplace Harper's Ferry, W. Virginia

16 (a) Informant Geraldine Johnson, daughter
(b) Address 3404 Duvall Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/21/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves

19 MAY 19 1947 Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18th 1947 at 6 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 1947 to May 18 1947, and that I last saw h[illegible] alive on May 18 1947

Immediate cause of death Pneumonia - Hemiplegia — Duration 1 week.

Due to Hypertension - Chronic Bronchitis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. B. McElwain
Address 31 E North Ave Date signed 5-19-47

H. B. McElwain

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C51843

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ Registered No. C51843

170c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County.....
(c) City or town Philadelphia
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2520 Sequoia Ave.
(If rural, give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Randall Phillips

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed or divorced~~.

6 (b) Name of husband or wife Alone

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/2/1921

8. AGE: Years 26 | Months 0 | Days 16 | If less than one day hr. min.

9. Birthplace Philadelphia Pa.
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER 12. Name Reynell W Phillips

13. Birthplace Kansas City

MOTHER 14. Maiden Name Catherine Myers

15. Birthplace Pittsburgh Pa

16 (a) Informant.....
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 21 47 (month) (day) (year)

(c) Cemetery or ~~crematory~~ Holy Sepulchre
Location Philadelphia Pa.

18 (a) Funeral director Wm. J. Tidwell
(b) Address North & Pennsylvania

19 (a) MAY 19 1947 (Date rec'd by registrar) Washington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1947, at 1.45 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture dislocation of 1st and 2nd cervical vertebrae (broken neck)

Due to Subdural hemorrhage of brain;

Other Conditions Lacerations and bruises; Fractured lower jaw
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-18-47 at 7:30 A M. Easton Co.
(b) Where did injury occur? Public Road near bridge
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? no
(d) Means of injury Three auto collisions

23. Signature J. Mencer M.D.
Medical Examiner.
Date signed 5-19-47

VS 151

G51844 Hughlett

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G51844

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 525 30th St - Belt. Blvd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 80 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 525 E. 30th St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Demaree Bowen

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: John Oswald Bowen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2 - 66

8. AGE: Years 80 | Months 11 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George Alexander Clark
13. Birthplace St Mary's County

MOTHER
14. Maiden Name Mary A. Cundiff
15. Birthplace Middlesex County Va

16 (a) Informant Eliza J. Saunders
(b) Address Aberdeen Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 17 1947 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto Md

18 (a) Funeral director Walter H. Archer
(b) Address Benson, Md.

19 (a) [illegible] (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1947 at 10 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 6 1946 to May 15 1947 and that I last saw her alive on May 15 1947.

Immediate cause of death	Duration
Acute obstruction jaundice	2 wks
Due to Carcinoma of Stomach	14 Mos
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Homer A. Todd M.D.
Address 2108 St Paul St Date signed 5/19/47

X

C51845

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83B

Registered No. C51845

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. For correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2435 Madison Ave.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2435 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Cornelia Cummings

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	W.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 23 1883

8. AGE: Years	Months	Days	If less than one day
63	7	25	hr. min.

9. Birthplace Galveston Texas
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John Morris
13. Birthplace Texas

MOTHER 14. Maiden Name Cornelia Baker
15. Birthplace Texas

16 (a) Informant Bertha Cummings
(b) Address 2435 Madison Ave.

17 (a) Burial (b) Date thereof 5-22-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Balto. City

18 (a) Funeral director Charles R. Law
(b) Address 802 Mad. Ave.

19 (a) MAY 19 1947 Huntington Williams M. D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-18- 1947 at 12 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-1- 1947 to 5-18- 1947 and that I last saw her alive on 5-18- 1947

Immediate cause of death	Duration
Coronary embolism +	1 month
Due to Thrombosis	
arteriosclerosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Irvin G. Thum M. D.
Address 2340 Madison Ave. Date signed 5-19-47

VS 150

G51816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G51816

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dod
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits write RURAL and give Ave
(d) Street No. 2818 Roselawn (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander Hamilton Hobbs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Mary V.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5-1868

8. AGE: Years 78 | Months 7 | Days 13 | If less than one day hr. min.

9. Birthplace Howard Co - Md. (Town, county, and state)

10. Usual Occupation Retired - Police dept

11. Industry or business

FATHER
12. Name Joseph F. Hobbs
13. Birthplace Md.

MOTHER
14. Maiden Name Isabelle Grossman
15. Birthplace Md.

16 (a) Informant Mrs. Mary V. Hobbs
(b) Address 2818 Roselawn Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/21/47 (month) (day) (year)

(c) Cemetery or crematory Baltimore
Location Baltimore

18 (a) Funeral director L. Kuck
(b) Address 5305 Harford Rd.

19 (a) MAY 19 1947 Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1947 at 6:35 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Helpich M.D. Medical Examiner.
Date signed May 18, 1947

G51847

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. G51847

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address W Fayette St
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3716 Yosemite Ave (If rural give location)
(e) Citizen of foreign country? Yosemite (Yes or No) If yes, name country

3 (a) FULL NAME Mrs Mary W. Brady

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Femal | 5. Color or race White | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife E L Brady

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 17 1891

8. AGE: Years 56 | Months 3 | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business Housewife

FATHER
12. Name Wm Ward
13. Birthplace Boston Mass

MOTHER
14. Maiden Name Margaret Wilkens
15. Birthplace Baltimore Md

16 (a) Informant E L Brady
(b) Address 3716 Yosemite Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 20-47 (Month) (day) (year)
(c) Cemetery or crematory Mt Lebanon
Location Old Frederick Rd

18 (a) Funeral director John A. Nolan
(b) Address 4801 Greenmount Ave

MAY 19 1947 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 May 1947, at 10 15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 13 March 1947 to 17 May 1947 and that I last saw h[illegible] alive on 27 May 1947

Immediate cause of death	Duration
Cardiac failure	
Due to Generalize abdominal Carcinomatosis 2nd to Metastatic	
Due to	
Other Conditions Ascites	FWW

(Include pregnancy within 3 months of death)

Date of operation 27 March 1947

Major findings of operation: Ascites and Generalized Ab. Carcinomatosis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph R Pilcher M. D.

Address B A Secna Hosp Date signed 17 May 47

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51818

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G51818 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St
(c) Hospital or institution: Bon Secours Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4½ Mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 26 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 408 N. Charles St (If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country ---------

3 (a) **FULL NAME** Most Rev Michael J. Curley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Single

6 (b) Name of husband or wife ---------

6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1879

8. AGE: Years	Months	Days	If less than one day
67	7	4	-- hr. --- min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Clergyman

11. Industry or business Archbishop of Balto.&

FATHER
12. Name Michael Curley
13. Birthplace Ireland

MOTHER
14. Maiden Name Maria Ward
15. Birthplace Ireland

16 (a) Informant S. R. Mears
(b) Address 805 N. Calvert St.

17 (a) Entombment (b) Date thereof 5/22/47 (month) (day) (year)
(c) ~~Cemetery or crematory~~ Catholic Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert St.

19 (a) MAY 19 1947 (b) Huntington Williams, M.D. Registrar

VS 200

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/16 1947 at 11.25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/5 1947 to 5/16 1947 and that I last saw h[illegible] alive on 5/16 1947.

	Duration
Immediate cause of death Respiratory Failure	Minutes
Due to Cerebral Hemorrhage	1 hour
Due to Hypertension	Unknown
Contributory Conditions	

(Include pregnancy within 3 months of death)
Date of operation ---
Major findings of operation
of autopsy ---

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gertrude A. Lyons M.D.
Address Bon Secours Hosp. Date signed 5/16/47

X

G51849
AB-98664

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 55E

Registered No. G51849

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr-3mos-21days
(e) Length of stay in Baltimore (yrs., mos., or days) 10yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 12
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: William Rea

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 5- 1860

8. AGE: Years 87 | Months 5 | Days 5 | If less than one day ____hr. ____min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Hugh Rea
13. Birthplace Ireland

MOTHER — 14. Maiden Name Elizabeth Band
15. Birthplace Wales

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School MAY 16 1947
18 (a) Funeral director [redacted]
(b) Address
MAY 19 1947 (Date rec'd by Registrar) [redacted]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1947, at 8.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-19- 1946 to 5-10 1947.
and that I last saw h in alive on 5-10- 1947.

Immediate cause of death: Squamous Cell Carcinoma, Lung — Duration: yrs
Due to: Arteriosclerotic CVD Arteriosclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Anatomical Board

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edmund Beacham M. D.
Address Balto City Hosp Date signed May 16, 47

G51850

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

✓ G51850 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 801 Dunbar St.
(c) Hospital or institution: Baltimore City Jail 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 48 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3 yrs ago (506 E. Lanvale St.)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Watson.

3 (b) If veteran, name war /
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: none
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1882
8. AGE: Years 65 Months Days If less than one day hr. min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Hunter Fish Fisher
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Dr. Thomas F. Wright
(b) Address Balto City Jail.

17 (a) to morgue (b) Date thereof 4/30/47.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School MAY 14 1947
18 (a) Funeral director Commissioner of Health
(b) Address
(a) Signature and title of local registrar
MAY 19 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/30/1947, at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/8/1947 to 4/30/1947, and that I last saw him alive on 4/29/1947.

	Duration
Immediate cause of death: Myocardial Infarction	4 days
Due to: Myocarditis	6 months
Due to: Generalized Arteriosclerosis	2
Other Conditions: Senile dementia	6 months

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas F. Wright M. D.
Address Balto City Jail Date signed 4/30/47

G51851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G51851 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully recorded. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 902 E. Preston St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 902 E. Preston St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Andrew J. Wooden

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-03-2235

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary B. Thornburg
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Jan 29 1890

8. AGE: Years	Months	Days	If less than one day
57	3	19	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Printer
11. Industry or business A S Abell Co.

FATHER
12. Name Henry W. Wooden
13. Birthplace Md

MOTHER
14. Maiden Name Wilhelmenia Seeger
15. Birthplace Germany

16 (a) Informant Mrs Mary Wooden
(b) Address 902 E. Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 19 1947 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Pete Wagerfield
(b) Address 900 E. Biddle St

MAY 19 1947 (Date filed by registrar) (b) Washington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 May 1947 19..., at 4 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 10 1947 to 17 May 1947, and that I last saw h... alive on 17 May 1947.

Immediate cause of death Coronary Thrombosis — Duration 1 hr 10 min

Due to Coronary Artery disease — Duration ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Lilienfeld M. D.
Address 714 E. Preston St. Date signed 18 May 47

Dr Lilienfeld

X

G51852

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

G51852 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4702 Harford Rd
(c) Hospital or institution: Harford Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1714 E. 31st St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie Melotte

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) ~~Single, married~~, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Arthur Melotte

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13th 1868

8. AGE: Years	Months	Days	If less than one day
78	11	4	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Charles Kramer
13. Birthplace Unknown

MOTHER
14. Maiden Name Amelia Bernasko
15. Birthplace Unknown

16 (a) Informant Chas. A. Hitchcock
(b) Address 1714 E. 31st St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/20/47 (month) (day) (year)
(c) Cemetery or crematory Balto
Location " Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

MAY 20 1947 (Date received by local registrar) (Signature) Funeral Director for Williams Cook Inc.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17th 1947, at 1:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 30 1947 to May 17 1947 and that I last saw h[illegible] alive on April 30 1947.

Immediate cause of death

Duration

Cardiac insufficiency — Short time

Due to

Due to Senile degeneration — 5 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Roscoe Y. Cross M. D.

Address 2438 Maryland Ave Date signed 5-19-47

G51853

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G51853

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 829 Cedarcroft Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 829 Cedarcroft Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Rohl

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, ~~widowed, or~~ divorced.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Clara Rohl
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 1st 1886

8. AGE: Years	Months	Days	If less than one day
61	2	16	hr. min.

9. Birthplace London England
(Town, county, and state)
10. Usual Occupation Hair Dresser
11. Industry or business Self

FATHER
12. Name Herman Rohl
13. Birthplace Germany

MOTHER
14. Maiden Name Sarah (Unknown)
15. Birthplace Germany

16 (a) Informant Clara Rohl
(b) Address 829 Cedarcroft Rd

17 (a) Burial (b) Date thereof 5/20/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Morland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

MAY 20 1947 (b) [illegible] for Wilmington Md.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19th 1947 at 2.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 21-April 1947 to 17-May 1947 and that I last saw h[illegible] alive on 17-May 1947.

Immediate cause of death Coronary Thrombosis — Duration Sudden

Due to Arteriosclerotic Cardio Vascular Disease — Duration April 47

Due to — Duration

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas. Edwards M. D.
Address 27 Hothe Alameda Date signed May 47

G51854 ✓ G51854

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Lafayette & Johns Sts
(b) Street address
(c) Hospital or institution: Womens Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 55da
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto City
(c) City or town ~~Catonsville~~ Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Hopkins Apts (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Blanche Carmine

3 (b) If veteran, name war: No
3 (c) Social Security Account No.

4. Sex: Fe | 5. Color or race: Wh | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10 June 1878

8. AGE: Years 68 | Months 11 | Days 9 | If less than one day: hr. min.

9. Birthplace Catonsville-Baltimo, Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Charles Garrett Carmine
13. Birthplace Accomac Va

MOTHER
14. Maiden Name Margaret A Carrigan
15. Birthplace Balto Md.

16 (a) Informant Laura V. Carmine
(b) Address Homewood Apts

17 (a) Burial (b) Date thereof 5/21/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 MAY 20 1947 (b) Registrar for Williamsville
(Date received by Registrar)

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/19 1947, at 7 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/25 1947 to 5/19 1947; and that I last saw h[illegible] alive on 5/19 1947:

Immediate cause of death: Resp. failure

Due to: Multiple Metastases

Due to: Carcinoma of breast

Other Conditions: Secondary anemia - severe.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

Duration: 20 mos.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wallace Dekent M.D.
Address 1127 St Paul St Date signed 5/19/47 M.D.

G51855

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G51855 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2105 Essex St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2105 Essex St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Rozalia Balcerzak

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Simon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 14 1881

8. AGE: Years	Months	Days	If less than one day
65	5	3	hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Wojciech Blazejczak
13. Birthplace Poland

MOTHER
14. Maiden Name Do Laszuka
15. Birthplace Poland

16 (a) Informant
(b) Address 2105 Essex St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 21 47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Ozarowski
(b) Address 1922 Eastern Ave

MAY 20 1947 (Date received by registrar) Thurlington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1947 to May 17 1947 and that I last saw h.. alive on May 17, 1947

Immediate cause of death: Bilateral Pneumonia (Tom Duke) — Duration: Acute
Myocardial Insufficiency
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Emma Krusewski M.D.
Address 2079 Eastern Ave Date signed 5/20/47

VB 150

G51856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G51856

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3009 Eastern Ave -
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (24)
(Outside city or town limits, write RURAL and give town)
(d) Street No. 3009 Eastern Ave.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Mary M. Adams

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Henry M. Adams (Deceased) | 6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 2, 1886

8. AGE: Years 61 | Months 1 | Days 15 | If less than one day — hr. — min.

9. Birthplace Anne Arundel County, Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Louis H. Reith
13. Birthplace Md.

MOTHER
14. Maiden Name ? ?
15. Birthplace Md.

16 (a) Informant Miss Margaret E. Adams (Daughter)
(b) Address 3009 Eastern Ave., Balto. 24, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 20 1947 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto. Co., Md.

18 (a) Funeral director G. Bowman Evans
(b) Address 1400 S. Charles St., Balto 30, Md.

19 MAY 20 1947 (Date received by registrar) (Signature of registrar) Millington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17, 1947, at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1947 to May 17 1947 and that I last saw h[illegible] alive on May 17 1947.

Immediate cause of death	Duration
Cerebral Arteriosclerosis C.V. Disease	
Chronic Myocarditis	3-1-47
Due to Fractured Left Femur	5-17-47
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature E. Eschenbrenner, M.D.
Address 842 N. Eutaw St. Date signed May 20 1947

G51857

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G51857

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write to the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT AND SARATOGA
(c) Hospital or institution:
MERCY HOSPITAL 28
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALT.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3612 ELDORADO AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MR. DAVID? MILLIMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M.

6 (b) Name of husband or wife MRS. LELIA MILLIMAN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB 22 1888

8. AGE: Years	Months	Days	If less than one day
59	2	27 24	hr. min.

9. Birthplace BALT., MD.
(Town, county, and state)
10. Usual Occupation
11. Industry or business AUTO ACCESSORIES.

FATHER
12. Name JACOB MILLIMAN
13. Birthplace POLAND

MOTHER
14. Maiden Name TOBA Kolnigsberg
15. Birthplace POLAND.

16 (a) Informant Mrs. Lelia Milliman
(b) Address 3612 Eldorado ave

17 (a) Burial (b) Date thereof May 20/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location 3400 E. Balto St

18 (a) Funeral director Sol Levinson & Bros.
(b) Address 1124-26 W. North ave
(c) Address of Registrar Washington Millimanner

MAY 20 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-18 1947 at 10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from APRIL 29 1947 to MAY 18 1947 and that I last saw h.IM. alive on MAY 18 1947

Immediate cause of death	Duration
RESP. FAILURE	
Due to UREMIA	
Due to CONGENITAL POLYCYSTIC KIDNEYS.	
Other Conditions ARTD.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jamaica Roberts M. D.
Address Mercy Hospital Date signed 5-18-47

VS 150

G51858

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G51858

Itzkowitz 469

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland ave
(c) Hospital or institution: Sinai Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 19
(If outside city or town limits, write RURAL and give town)
(d) Street No. Fairdale Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Itzkowitz

3 (b) If veteran, name war

(c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Late Louis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
71			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Israel Caplan
13. Birthplace Russia

MOTHER
14. Maiden Name Ida
15. Birthplace Russia

16 (a) Informant Mrs. Ethel Silver
(b) Address Detroit Mich

17 (a) Burial (b) Date thereof May 20/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Potters Herring Run
Location Bowley Lane

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-26 W. North ave

MAY 20 1947 (b) Registrar Wellington Williams MD

V S 130

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 19 47 at 6:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 25 19 47 to May 19 19 47, and that I last saw h alive on May 19 19 47

Immediate cause of death	Duration
Carcinomatosis	
Due to	
Due to	over
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation May 7, 1947

Major findings of operation: Carcinomatosis with ascites

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Allan H. Mucht M.D.
Address Sinai Hosp Date signed 5/19/47

X

G51859

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G51859

167

Every item of information should be carefully supplied. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 12-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 417 Merryman Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DUNCAN Mc LEAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Ida

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/11/1902

8. AGE: Years	Months	Days	If less than one day
45	3	7	hr. min.

9. Birthplace Red Springs, N.C.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Brown McLean
13. Birthplace N.C.

MOTHER
14. Maiden Name Annie Blue
15. Birthplace N.C.

16 (a) Informant Ida McLean
(b) Address 417 Merryman Lane

17 (a) Burial (b) Date thereof 5-22-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location Balto County Md

18 (a) Funeral director William G. Jackson
(b) Address 916 Lemmon Ave.

19 MAY 20 1947 [illegible] Registrar
(Date received by reg.)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18, 1947, at 4:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hemorrhage due to
stab wound of left sub-clavian vein

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-18-47 at 4 P. M.
(b) Where did injury occur? Back yard of 3213 Barclay Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Sharp Instrument

23. Signature Earl L. Kaylor M.D.
Medical Examiner.
Date signed 5-19-47

G51860

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G51860

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 228 Beale Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 228 Beale Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Georgette Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 18, 1864

8. AGE: Years	Months	Days	If less than one day
83	3		hr. min.

9. Birthplace Royal Oak, Md. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Joshua Forrest
13. Birthplace Mass

MOTHER
14. Maiden Name Amanda Augustus
15. Birthplace Md.

16 (a) Informant Mrs. Helen Chester
(b) Address 228 Beale Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-22-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

MAY 20 1947 (Date received by Registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18, 1947, at 5P M

21. I certify that death occurred on the date above stated, that I attended deceased from 5/14 1947 to 5/18/1947 and that I last saw [illegible] alive on 5/18/1947

	Duration
Immediate cause of death	
Due to	2 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature
Address Date signed 5/19/47

G51861

JL - 110105

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

110 B

Registered No. G51861

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Type correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 638 S. Pappolla St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Baron -Or- Baranowski

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-09-6431

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 18, 1893

8. AGE: Years	Months	Days	If less than one day
53	8	1	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Machinists
11. Industry or business Crown Cork & Seal

FATHER
12. Name Joseph Baron
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Laskowski
15. Birthplace Germany

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 5-22-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A. Weber
(b) Address 705 South Ann Street

19 (a) MAY 20 1947 (b) [illegible] for Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION AM

20. DATE OF DEATH May 19, 1947 19..., at 11:30M

21. I certify that death occurred on the date above stated; that I attended deceased from April 22 1947, to May 19 19 47, and that I last saw h in alive on May 19 19 47.

Immediate cause of death	Duration
Cardiac Failure	Immediate
Due to Subacute glomerulo-nephritis	
Due to	
Other Conditions (1) Subacute pericarditis (2) Subacute pleurisie left	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edwin C. Evans M. D.
Address Balto. City Hospitals Date signed 5-19-47

VS 150

130

G51862 A C 8067

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G51862

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 14 D.U.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1527 Myrtle Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Reginald William Shacklet

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-18-47

8. AGE: Years | Months | Days: 3 wks | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Winfield
13. Birthplace Md

MOTHER
14. Maiden Name Marie Shacklett
15. Birthplace Md

16 (a) Informant Maire Shacklett
(b) Address 1527 Myrtle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/19/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Arburn
Location Baltimore City

18 (a) Funeral director J. Brown & Son
(b) Address 108 W. Montgomery Street

19 (a) Filed MAY 20 1947 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16, 1947, at 10.30 P M

21. I certify that I took charge of the remains described above, held an insp.&inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earle Royster M.D.
Medical Examiner.
Date signed 5-19-47

X

G51863

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. G51863

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital 6.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) 21 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. 31
(If outside city or town limits, write RURAL and give town)
(d) Street No. 415 N. Chester St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William O. Teichman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Anne Teichman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 7 1886

8. AGE: Years	Months	Days	If less than one day
60 59	67	12	hr. min.

9. Birthplace New York, N.Y.
(Town, county, and state)
10. Usual Occupation Watchmaker
11. Industry or business

FATHER
12. Name Louis Teichman
13. Birthplace Roumania

MOTHER
14. Maiden Name Annette ?
15. Birthplace Roumania

16 (a) Informant Anne Teichman
(b) Address 415 N Chester St.

17 (a) Burial (b) Date thereof 5-20-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Herzeg Rum

18 (a) Funeral director Jack Leitess Inc
(b) Address 1419 E Balto St

MAY 20 1947
(Date filed by registrar) Huntington Williams Reg

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-19 1947, at 2 40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-25 1947 to 5-19 1947 and that I last saw him alive on 5-19 1947

	Duration
Immediate cause of death Respiratory Failure	2 days
Due to Carcinomatosis	2 mos
Due to Carcinoma of Rectum	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William D. Gentry M.D.
Address Mercy Hosp Date signed 5-19-47

VS 150

X

G51864

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G51864 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 419 W. Fayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL TOMIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years	Months	Days	If less than one day
58			hr. min.

9. Birthplace New York (town, county, and state)

10. Usual Occupation Clerk

11. Industry or business

FATHER
12. Name unknown
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Max Klar

(b) Address 2227 Wilkens Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-21-47 (month) (day) (year)

(c) Cemetery or crematory United Hebrew

Location Washington Boulevard

18 (a) Funeral director Jack Lewis Inc

(b) Address 1459 E Balto St

MAY 20 1947 (Date rec'd by registrar) (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/19/47 19 7:30 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Weis M.D.
Medical Examiner.
Date signed 5/19/47

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G51865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G51865

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2616 Oswego Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-13
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2616 Oswego Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hanna Lurie

3 (b) If veteran, name war | 3 (c) Social Security Account No.

Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Solomon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years 72 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Samuel
13. Birthplace Russia

MOTHER 14. Maiden Name Bessie
15. Birthplace Russia

16 (a) Informant Solomon Lurie
(b) Address 2616 Oswego ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-21-47 (month) (day) (year)
(c) Cemetery or crematory Hebrew Young Men
Location Druid Hill Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E Balto St

19 (a) MAY 20 1947 (Date received by Registrar) Washington Williams M.D. Registrar
(b)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-20-1947, at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 9 1946 to May 20 1947, and that I last saw h.. alive on May 20 1947.

	Duration
Immediate cause of death: Cerebral Hemorrhage	Unknown
Due to: Hypertension + Arteriosclerosis	5 or 6 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David A. Kolowich M.D.
Address 3700 Park Heights Ave Date signed May 20 1947 M. D.

G51866 G51866

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2928 Guilford Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2928 Guilford Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CLARA VIRGINIA JEFFRIES

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife: Jos. L. Jeffries
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Apr. 29, 1860

8. AGE: Years	Months	Days	If less than one day
87	0	20	hr. min.

9. Birthplace: Balto., Md. (Town, county, and state)
10. Usual Occupation: None
11. Industry or business

FATHER
12. Name: Michael Bulack
13. Birthplace: Germany

MOTHER
14. Maiden Name: Margaret Cole
15. Birthplace: Balto.

16 (a) Informant: Mr. Wm. E. Jeffries
(b) Address: 2928 Guilford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/22/47 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto., Md.

MAY 20 1947 (Date received by Registrar) (Signature of Registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19, 1947, 8:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 18 1947 to May 19 1947 and that I last saw h[illegible] alive on May 18 1947

Immediate cause of death: Coronary occlusion — Duration: 1 Day
Due to: Arterio sclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence No at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? No While at work? No (Specify type of place)
(e) Means of injury
23. Signature: [illegible] M.D.
Address 2808 Al[illegible] Date signed 5/19/47

Howard J. Clemens, M.D.

G51867

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G51867
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Arena Sts.
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7224 Eastern Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ADDIE MAY SMITH

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	divorced

6 (b) Name of husband or wife Thomas H. Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1883

8. AGE: Years	Months	Days	If less than one day
63	11	29	hr. min.

9. Birthplace Howard Co., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Ezekiel Cavey
13. Birthplace Md.

MOTHER
14. Maiden Name Rebecca Tacey
15. Birthplace Md.

16 (a) Informant Mrs. Raymond Liedlich
(b) Address 7224 Eastern Blvd.

17 (a) Burial (b) Date thereof 5/21/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAY 20 1947 (b) Huntington Williams M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1947, at 7:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 18 1947 to May 19 1947, and that I last saw him alive on May 19 1947

Immediate cause of death Coronary thrombosis

Due to Arteriosclerotic cardiovascular degeneration

Due to

Other Conditions Diabetes mellitus. Duodenal hypochromic anemia. Hypoglycemia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles R. Holmes M. D.
Address Univ. Hosp. Date signed 5/19/47

937

G51868 G51868

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct ago is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1151 Scott St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Holsey. Holsey

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret S. Holsey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 7, 1872

8. AGE: Years	Months	Days	If less than one day
74	6	12	hr. min.

9. Birthplace Maryland (Balto.) (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name WM. HOLSEY
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Mary E Brann
(b) Address 1151 Scott St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/22/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAY 20 1947 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19, 1947, at 12:40 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 14 1947, to May 19 1947, and that I last saw h. alive on May 14 1947.

Immediate cause of death: Cardiac Failure

Due to: Arteriosclerotic Heart Disease

Due to: generalized Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Rocco L. Lafaneto M. D.
Address Lo. Balto. Gen. Hosp. Date signed 5-19-47

VS 150

X

G51869

BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G51869

CERTIFICATE OF DEATH

MAY 20 1947

8:30a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 426 N. Carey St.
(c) Hospital or institution:

19-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 426 N. Carey St. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME SADIE IRVING TYLER

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife George
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/13/1894

8. AGE: Years	Months	Days	If less than one day
53	3	4	hr. min.

9. Birthplace Jarrett, Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Richard Lewis
13. Birthplace Jarrett, Va.

MOTHER
14. Maiden Name Nellie Mason
15. Birthplace Jarrett, Va.

16 (a) Informant Geroge Tyler(H)
(b) Address 426 N.Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/20/47 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem'l. Pk.
Location Balto. County, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N.Carrollton Ave

MAY 20 1947 (Date received by registrar) (b) [signature]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17th 1947, at 5 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 3 1947 to May 17 1947 and that I last saw her alive on May 16 1947.

Immediate cause of death: Cerebral Hemorrhage — Duration: 2 wks
Due to: Hypertension
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Walter Sharrington M. D.
Address 201 N. Carey Date signed 5/19/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

651870

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V-13P

Registered No. 651870

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1007 Broadway
(c) Hospital or institution: Mercy 16-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1007 Broadway (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Phillip Rich

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Mary Rich
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/19/1900

8. AGE: Years	Months	Days	If less than one day
47	7	29	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Warren Rich
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Dorsey
15. Birthplace Md.

16 (a) Informant Mary Rich
(b) Address 1007 Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/22/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Md.

18 (a) Funeral director Chas. G. Nelson
(b) Address 1313 Freedman Pl.

19 (Filed) MAY 20 1947 (Registrar) Covington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/18/47 19 7:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/14/47 to 5/16/47, and that I last saw h alive on 5/16/47

Immediate cause of death Pulmonary Edema
Due to Acute Pulmonary Tuberculosis

Duration: 5 mos

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. Lee Ellis M. D.
Address 5 E Mt. Vernon Pl. Date signed 5/20/47

VS 150

X

G51871

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 877

G51871 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 S. Athol Ave.
(c) Hospital or institution General German Aged People Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 22 S. Athol Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George L. Voigt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M.

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Lottie Nellie Voight

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 13, 1868

8. AGE: Years 79 | Months 4 | Days 5 | If less than one day hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Frederick A. Voigt

13. Birthplace Germany

MOTHER 14. Maiden Name Catherine Kirchgessner

15. Birthplace Germany

16 (a) Informant Mrs. J. Geo. Wahl (Sister)

(b) Address 22 S. Athol Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 21/47. (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location 4300 Old Frederick Rd.

18 (a) Funeral director Henry H. Kirkus

(b) Address 410 N. Edmondson Ave.

MAY 20 1947 (Date rec'd by registrar)

(b) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18/47. 19..., at 7.05 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 8/47. to May 18/47.
and that I last saw h im alive on May 17/47.

Immediate cause of death	Duration
Broncho-Pneumonia	3 days
Due to	
Due to	
Other Conditions Unknown. Multiple Sclerosis. (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Woods Clevenger

Address 933 Hanover St. Date signed May 18/47.

VS 160

107

G51872

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 65a

Registered No. G51872

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert - Saratoga
(c) Hospital or institution: Mercy Hosp 28
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3105 Milford Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eleanor Nooney Eleanor Wellen Mooney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mr. Nooney

6 (c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): May 26 - 1883

8. AGE: Years: 61 Months: 11 Days: 22 If less than one day: hr. min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business: At Home

FATHER
12. Name: Andrew O Miller
13. Birthplace: Md

MOTHER
14. Maiden Name: Julia Blondell
15. Birthplace: Md

16 (a) Informant: Husband John D. Mooney
(b) Address: 3105 Milford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/21/47 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Old Frederick Rd.

18 (a) Funeral director: E. Wallis Lanahan
(b) Address: 4510 Liberty Heights Ave

19 (a) MAY 20 19 (b) Washington Nilliams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-18 1947; at 8:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-9 1947 to 5-18 1947 and that I last saw h[illegible] alive on 5-18 1947

Immediate cause of death	Duration
Cardiac failure	
Due to: Addison-like syndrome	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: [signature] M.D.
Address: Mercy Hosp Date signed: 5/18/47

VS 150

G51873
AB-109914

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 124C

Registered No. G51873

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo 27th
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 730 S. Charles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Taylor

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?- 1864?

8. AGE: Years	Months	Days	If less than one day
83?	?	?	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George
13. Birthplace Va.

MOTHER
14. Maiden Name Margaret
15. Birthplace Va.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof 5 20 47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Balto.
18 (a) Funeral director Walter A. Griggs
(b) Address 1321 W. Fenby Ave.
19 MAY 20 1947 Timothy Jos. Williams M.D.

MEDICAL CERTIFICATION PM

20. DATE OF DEATH May 16- 1947 19 47, at 10.30

21. I certify that death occurred on the date above stated; that I attended deceased from 4-16 19 47 to 5-16 19 47, and that I last saw h im alive on 5-16 19 47.

Immediate cause of death: Cardiac Failure — Duration: yrs.
Antecedent C.V.D. — Term
Morbid conditions: Bronchopneumonia
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy: Art. C.V.D. Cirrhosis of liver, mod

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edmund Beasley M. D.
Address Balto. Md. Date signed May 21 47

VS 150

93D

G51874

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G51874

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 221 N. Rose St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) - If yes, name country

3 (a) FULL NAME Ludwig D. Persio

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-20-4927

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10 1924

8. AGE: Years	Months	Days	If less than one day
22	9	7	hr. min.

9. Birthplace Baltimore Md. (Town, county and state)

10. Usual Occupation Stock Clerk

11. Industry or business Continental Can Co. Type

FATHER
12. Name Augusto De Persio
13. Birthplace Italy

MOTHER
14. Maiden Name Marsilia De Angelis
15. Birthplace Italy

16 (a) Informant August De Persio (Father)
(b) Address 221 N. Rose St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 21st/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Wella Vell
(b) Address 52 N. Morley St.

19 MAY 20 1947 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1947, at 2:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/4 1947 to 5/17 1947, and that I last saw him alive on 5/17 1947.

Immediate cause of death	Duration
Cardio-respiratory Failure	
Due to Septicemia (Staphylococcus)	
Due to Bronchopneumonia Purulent Pleurisy	
Other Conditions Uremia & Chr. nephritis (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation: Miliary tuberculosis

of autopsy Bilateral hypostatic pneumonia

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury O.W.E.K.

23. Signature Arthur Lower M.D.
Address St. Josephs Date signed 5/17/47

G51875

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

Registered No. G51875

FREE

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 521 Moore Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willie Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years 80 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace ?
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant ?
(b) Address

17 (a) Burial (b) Date thereof May 20 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mount Albourn
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave

19 MAY 20 1947 (b) Huntington Rutledge
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16, 1947, at 12 P.M. SI

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Generalized Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner.
Date signed 5-17-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

X

G51876 Ward Room 1 52 pm

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G51876

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied correct are is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2036 E. Hoffman St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Carrie Lockeman

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: W Married
6 (b) Name of husband or wife: John A. Lockeman
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 6 1886
8. AGE: Years 60 | Months 10 | Days 12 | If less than one day hr. min.
9. Birthplace Md Maryland (Town, county and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Thomas Sunderland
13. Birthplace England

MOTHER
14. Maiden Name Virginia Hoges
15. Birthplace ?

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 13 47 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Mem Pk
Location Alkyd Md
18 (a) Funeral director Philip Sterling Sons
(b) Address 2124 Eutaw St
19 (c) MAY 20 1947 (Date rec'd by registrar) Washington Millington Md

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1947, at 1 52 PM
21. I certify that death occurred on the date above stated; that I attended deceased from 5-18 1947 to 5-18-1947 and that I last saw h[illegible] alive on 5-18-1947

Immediate cause of death	Duration
Arteriosclerotic + hypertensive cardio-vascular disease with acute	15 yrs
Due to Cardiac decompensation	?2 hrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Robert E. Mason M. D.
Address Johns Hopkins Hosp Date signed 19 May 47

VS 150

X

C51877 TL - 89100

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C51877

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 1-5
2 - 9 - 28
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 31 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2109 E. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lizzie McLean

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Wm. Henry McLean
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6, 1887

8. AGE: Years	Months	Days	If less than one day
60	2	12	hr. min.

9. Birthplace England (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Marshall
13. Birthplace Scotland

MOTHER
14. Maiden Name Sara Holland
15. Birthplace England

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/21/47 (month) (day) (year)
(c) Cemetery or crematory St. Paul's Fifth Ref
Location Baltimore, Md. (Ch. Cem.

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY

19 (a) MAY 20 1947 (Date received by local registrar) (b) Washington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18, 1947, at 8:45 am

21. I certify that death occurred on the date above stated; that I attended deceased from July 21 1944 to May 18 1947, and that I last saw h.er alive on May 18 1947.

Immediate cause of death	Duration
Cardiac Failure	3 yrs.
Arteriosclerosis CVD-	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same as above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edmund Beeman M. D.
Address Baltolit Hosp. Date signed 19 May 47

X

G51878 Hoffmeyer

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 148a

Registered No. G51878

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 909 N. Lakewood Av
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 909 N. Lakewood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edith M. Hoffmeyer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband ~~or wife~~ John J. Hoffmeyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 27 1887

8. AGE: Years 59 | Months 7 | Days 18 20 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry Deisinger
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Not Known
15. Birthplace " "

16 (a) Informant Mrs. Fiona Mulligan
(b) Address 909 N. Lakewood Av.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/21/47 (month) (day) (year)
(c) Cemetery or crematory Fulton Park
Location Balto. Md.

18 (a) Funeral director C. D. Fanning & Son
(b) Address 1638 E. Lafayette Ave.

19 MAY 20 1947 (Date rec'd by registrar) (b) Washington Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1/47 19 to 5/17/47 19, and that I last saw her alive on 5/17/47 19

Immediate cause of death	Duration
Carcinoma Cervix	6 mos
Due to	
Due to	
Other Conditions Metastatic Liver	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature F. W. Finnegan M. D.
Address 1710 E. 33rd St. Date signed 5/19/47

X

Zipp

051879

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1913

Registered No. 051879

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians:- please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St + Linden Ave
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1728 N. Washington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Zipp

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Walter Zipp
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 15 Sept 1860

8. AGE: Years	Months	Days	If less than one day
66	8	24	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Schnepp
13. Birthplace Germany

MOTHER
14. Maiden Name Christina Shane
15. Birthplace Balto. Md.

16 (a) Informant Walter Zipp
(b) Address 1728 N. Washington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/21/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto.

18 (a) Funeral director E. J. Fanning & Son
(b) Address 1938 E. Lafayette Ave

19 MAY 20 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 May 1947, at 1201 M

21. I certify that death occurred on the date above stated; that I attended deceased from 15 May 1947, to 19 May 1947, and that I last saw h[illegible] alive on 19 May 1947

Immediate cause of death	Duration
Cardiac decompensation	3 wks
Due to Rheumatic Heart disease	40 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. Allan Spiel, M.D.
Address Maryland Gen. Hosp. Date signed 19 May 47

X

G51880

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G51880

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 706 W. Fayette St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 706 W. Fayette (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROLLIN HUGHES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Esther

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 6, 186

8. AGE: Years 79 | Months 3 | Days 29 | If less than one day hr. min.

9. Birthplace Scranton, Pa. (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Unemployed

FATHER
12. Name Richard J. Hughes
13. Birthplace Unknown

MOTHER
14. Maiden Name Elizabeth Williams
15. Birthplace Scranton Pa

16 (a) Informant Elizabeth Taylor
(b) Address 5838 Market St, Phila

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 5-20-47 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore, Md.

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul St.

19 (Date received by registrar) MAY 20 1947 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/5/47, 19, at 10.40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Weaver M.D. Medical Examiner.
Date signed

VS 191

G51881

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G51881

CERTIFICATE OF DEATH 157E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mass (b) County
(c) City or town Woburn (If outside city or town limits, write RURAL and give town)
(d) Street No. 188 Salem St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Donna Marie Gately

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-24-46

8. AGE: Years | Months: 7 | Days: 15 | If less than one day: 25 hr. min.

9. Birthplace: Mass (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name: William Gately
13. Birthplace: Mass

MOTHER
14. Maiden Name: Madeline McLaughlin
15. Birthplace: Mass

16 (a) Informant: JOHNS HOPKINS HOSPITAL Records
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 5-21-47 (month) (day) (year)
(c) Cemetery or crematory Calvary
Location Woburn, Mass

18 (a) Funeral director: G. Howard Strong
(b) Address: 350 W North Ave

19 (a) MAY 20 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1947, at 4:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 6 1947 to May 19 1947, and that I last saw him alive on May 19 1947

	Duration
Immediate cause of death: Respiratory failure	10 min.
Due to: Congenital Heart disease	7 mo
Due to:	
Other Conditions: Fibrocardia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Albert J. Sheldon M.D.
Address: Johns Hopkins Hosp. Date signed 5/20/47

X

G51882

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G51882

BC# B79056

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: Sinai Hosp. Gen'l Hosp 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 41 E. Montgomery St. (If rural give location)
(e) Citizen of foreign country? Md. (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Carneal.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 15 May 47

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert Carneal
13. Birthplace Baltimore

MOTHER
14. Maiden Name Evelyn Hendley
15. Birthplace Baltimore

16 (a) Informant mother
(b) Address 41 E. Montgomery St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location

18 (a) Funeral director Body Retained
(b) Address for a specimen

MAY 20 1947 Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 16 May 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 15 May 1947, to 16 May 1947, and that I last saw her alive on 15 May 1947.

Immediate cause of death Respiratory failure — Duration

Due to 36 week gestation

Due to (Post-mortem)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Cohen
Address Sinai Hosp Gen'l Hosp Date signed 16 May 47

VS 150

G 1883 AB-12705

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

117a

Registered No. G51883

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Underline the cause to which death should be charged statistically. Where correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 14-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15yrs- 11mos- 23days
(e) Length of stay in Baltimore (yrs., mos., or days) 77yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 616 W. Lafayette Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Isaac C. Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	Widowed

6 (b) Name of husband or wife Halleh (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4 (1861) 186

8. AGE: Years	Months	Days	If less than one day
86	2	14	hr. min.

9. Birthplace St. Mary's Co., Maryland (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name George Henry Brown
13. Birthplace Maryland

MOTHER
14. Maiden Name Harriett ?
15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 21, 1947 (month) (day) (year)
(c) Cemetery or crematory St. Peters
Location Baltimore, Md.

18 (a) Funeral director Jas. Edgar H. Holland
(b) Address 1631 Druid Hill Ave.

MAY 20 1947 (Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18- 1947 at 1.20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-25- 1931 to 5-18- 1947, and that I last saw him alive on 5-18 1947

Immediate cause of death	Duration
Terminal bronchopneumonia	days.
Due to Arteriosclerosis, gen'l.	yrs.
Due to	
Other Conditions Gastric Ulcer with malignant degeneration (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: as above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
D: Signature Edmund B. Beacham
Address Balto City Hosp Date signed 20 May 47

G51884

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G51884

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4646 Kenwood Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4646 Kenwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pearl H. Perry

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or ~~wife~~ Robert R.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12 1868

8. AGE: Years 79 | Months | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business at Home

FATHER 12. Name Hicks
13. Birthplace Baltimore

MOTHER 14. Maiden Name Mary Cole
15. Birthplace Baltimore Md

16 (a) Informant Florence E. Forte
(b) Address 4646 Kenwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 21 1947 (month) (day) (year)
(c) Cemetery or crematory Baltimore Comm
Location E. North Ave

18 (a) Funeral director John E. Moran
(b) Address 3600 Baltimore St

MAY 20 1947 (b) Huntingtown Millersville, Md
(Date received by Registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1947 at 1830 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10 1947 to May 17 1947, and that I last saw her alive on May 17 1947.

Immediate cause of death: Cerebral Hemorrhage | Duration 5 yrs.

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M E Cole M. D.
Address 6014 York Road Date signed 5-17-47

X

G51885

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G51885

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully examined. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address LAFAYETTE AND JOHN
(c) Hospital or institution:
HOSPITAL FOR THE WOMEN OF MARYLAND
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7'
(e) Length of stay in Baltimore (yrs., mos., or days) 27

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3903 FORDHAM DRIVE
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country —

3 (a) FULL NAME FANNY — PATZ

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: HARRY J PATZ

6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) APR 12 1906

8. AGE: Years 41 | Months 1 | Days 7 | If less than one day ____ hr. ____ min.

9. Birthplace PENNSYLVANIA (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business HOME

FATHER
12. Name MAX JONAS
13. Birthplace GERMANY

MOTHER
14. Maiden Name SARAH ROTHSCHILD
15. Birthplace NEW YORK N.Y.

16 (a) Informant HARRY J. PATZ
(b) Address 3903 FORDHAM DR. - BALTO. MD

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/21/47 (month) (day) (year)
(c) Cemetery or crematory Balto. Hebrew
Location Balto. Md.

18 (a) Funeral director Marion Sonderling & Son
(b) Address 1829 Eutaw Place

19 (a) MAY 20 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VE 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 May 1947, at 2:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10 March 1947 to 19 May 1947, and that I last saw her alive on 19 May 1947.

Immediate cause of death	Duration
CARDIO RESPIRATORY FAILURE	
Due to MULTIPLE METASTASES	± 8 Mo.
Due to CARCINOMA OF THE BREAST (RIGHT)	4 YRS.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Fred B. Agee M. D.
Address Woman's Hosp. Date signed 19 May 47

Fredericks B. Agee X

G51886

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G51886

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospt. / 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 67 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Alhambra Apts. Lake Drive Cts
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Hattie H. Fuld

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Solomon Fuld
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5, 1879

8. AGE: Years 68 | Months 11 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation None.

11. Industry or business

FATHER 12. Name Solomon Haas
13. Birthplace Germany

MOTHER 14. Maiden Name Gusta Appele
15. Birthplace Germany

16 (a) Informant Mr. Philip S. Fuld
(b) Address Alhambra Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/21/47 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director David Sonnheim & Son
(b) Address 1902 Eutaw Place

19 (Registrar) MAY 20 1947 Thurlington Hillegass, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1947, at 7:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 5 1947 to May 18 1947 and that I last saw h.. alive on May 18 1947

Immediate cause of death	Duration
Heart failure	
Due to Arteriosclerotic Heart Disease	
Due to	
Other Conditions Diabetes mellitus Fracture, hip - rt.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 13/1
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 5-4-47 at ? M
(c) Where did injury occur? Alhambra Apts, Lake Drive (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? no
(Specify type of place)
(e) Means of injury Accidental fall 108

23. Signature Joseph C. Pleet M. D.

Address Union Mem'l Hosp. Date signed May 18 1947

Howard J. Thomsen, Md. 193

C51887

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 589

Registered No. C51887

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 259 N. Bruce St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 259 N. Bruce St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Martha Ellensworth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col.	Married

6 (b) Name of husband or wife Horace Ellensworth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16 1903

8. AGE: Years	Months	Days	If less than one day
44	4	-	hr. min.

9. Birthplace Laurel Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Hebron
13. Birthplace Md.

MOTHER
14. Maiden Name Susie Weston
15. Birthplace Md.

16 (a) Informant Horace Ellensworth
(b) Address 259 N. Bruce St.

17 (a) Burial (b) Date thereof 5-20-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winans

18 (a) Funeral director Wm. Rollin R. Williams
(b) Address 2347 N. Schroeder Ave.

19 MAY 20 1947 (b) Huntington Williams
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/16 1947, at 2:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/2 1946 to 5/16 1947.
and that I last saw h[illegible] alive on 5/16 1947.

Immediate cause of death	Duration
Congestive Heart Failure	3 wks
Due to Rheumatic Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. W. Neuhaus, M.D.
Address 426 N. Johns Date signed 5/16/47

VS 150

G51888

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G51888

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5884 Belair Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-4
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5884 Belair Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Schirmer Grandy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F.

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Benedict Grandy

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) May 24-1865

8. AGE: Years 81 | Months 11 | Days 24 | If less than one day ____ hr. ____ min.

9. Birthplace: Germany (Town, county, and state)

10. Usual Occupation: At home

11. Industry or business

FATHER
12. Name: Johann Schirmer
13. Birthplace: Bavaria, Germany

MOTHER
14. Maiden Name: Eva (Unknown)
15. Birthplace: Bavaria, Germany

16 (a) Informant: Mrs. George Grandy
(b) Address: 5884 Belair Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/21/47 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Balto

18 (a) Funeral director: L. J. Lyck
(b) Address: 5305 Harford Rd.

19 (Date rec'd by registrar) MAY 20 1947 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 18th 1947 at 3 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 24, 1945 to May 18, 1947 and that I last saw her alive on May 17, 1947.

Immediate cause of death	Duration
Myocardial Insufficiency	6 days
Due to Myocardial Disease	Several years
Due to Arterio-sclerosis	Many yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: A. L. Wilkinson, M. D.
Address: 5713 Belair Rd. Date signed: 5-19-47

VS 190

G51889 G51889

BALTIMORE CITY HEALTH DEPARTMENT

BC# B-78466 CERTIFICATE OF DEATH 159 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital or institution: St. Joseph's Hosp. 6-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, give township or county)
(d) Street No. 313 N. BROADWAY
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Arnold Avery Eller, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1947

8. AGE: Years | Months | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Arnold Avery Eller.
13. Birthplace Purlear, N.C.

MOTHER
14. Maiden Name June L. Hagerman
15. Birthplace Baltimore, Md.

16 (a) Informant June L. Eller (Mother)
(b) Address 313 N. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/21/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Md.

18 (a) Funeral director L. J. Ruck
(b) Address 5305 Harford Road

19 (a) MAY 20 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15, 1947, at 12:32 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 14, 1947 to May 15, 1947 and that I last saw h[illegible] alive on May 15, 1947

Immediate cause of death Anoxia — Duration

Due to Respiratory Obstruction

Due to Laryngeal Webbing.

Other Conditions Prematurity

None
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation

of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Anthony F. D'Paula M.D.
Address St. Joseph's Hospital Date signed 5/16/47

VS 150

G51890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G51890 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5020 Belair Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5020 Belair Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Antonetta Carbone

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Louis Carbone

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 23, 1871

8. AGE: Years 76 | Months - | Days 25 | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Liberato Giudice
13. Birthplace Italy

MOTHER
14. Maiden Name Rosa ?
15. Birthplace Italy

16 (a) Informant Miss Raphael D iudice
(b) Address 5020 Belair Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/21/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) MAY 20 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18th, 19 47, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 19 47 to May 15 19 47 and that I last saw her alive on May 15 19 47.

Immediate cause of death	Duration
Acute Coronary Insufficiency	
Due to	
Due to Ch Arteriosclerosis	
Other Conditions Ch Hypertension	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. L. Bornstein M. D.
Address 733 Arquith St Date signed 5/20/47

V S 150

G51891

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G51891

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1311 Glyndon Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1311 Glyndon Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Magdalene M. Strunge

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Gerasa

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 71 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name ?
13. Birthplace Lithuania

MOTHER
14. Maiden Name ?
15. Birthplace Lithuania

16 (a) Informant Alice Lacs
(b) Address 1311 Glyndon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/21/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Joseph F. Gonella Inc
(b) Address 1 Christopher Place

MAY 20 1947
(Date rec'd by registrar) Washington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 14 1946 to May 17, 1947 and that I last saw h.. alive on May 17, 1947.

Immediate cause of death	Duration
Carcinoma of Stomach	6 mos.
Due to	
Due to	
Other Conditions Metastasis to liver	1 mos.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Medical Arts Bldg. Date signed 5/20/47

VS 150

G51892

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G51892 Registered No. 3647

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1122 Carey St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1122 N. Carey St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Jane Davis

3 (b) If veteran, name war No

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race colored | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Stephen Davis

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 14 1872

8. AGE: Years	Months	Days	If less than one day
74	7	6	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business own home

FATHER
12. Name Thomas Thomas
13. Birthplace Virginia

MOTHER
14. Maiden Name Sophia Gregory
15. Birthplace Virginia

16 (a) Informant Sophia Pearman
(b) Address 1122 Carey St.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 5-20-47 (month) (day) (year)
(c) Cemetery or crematory Smithfield
Location Smithfield Virginia

18 (a) Funeral director Raymer Saunders
(b) Address 1412 E. Preston St

19 (a) (Signature of) Huntington Williams, M.D. (b) Registrar

MAY 20 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 — 20 — 1947, at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-11 1946 to 5 26 1947 and that I last saw him alive on 5-19-1947

Immediate cause of death: Gastric Carcinoma — Duration: one year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank A. Saunders M. D.
Address 1029 N. Stricker St Date signed 5-20-47

105—150

X

G53893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

103

Registered No. G53893

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert
(c) Hospital or institution: Mt Vernon Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 340 E 22nd St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Kathryn Gessel Hiebler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Peter Nicklas Hiebler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21, 1920

8. AGE: Years	Months	Days	If less than one day
26	11 9	29	hr. min.

9. Birthplace Massachusetts (Town, county, and state)

10. Usual Occupation Housewife - Waitress

11. Industry or business Worked at Wilson Restaurant

FATHER
12. Name Charles Gessel
13. Birthplace Boulton Md.

MOTHER
14. Maiden Name Hilda C. Johnson
15. Birthplace Nova Scotia

16 (a) Informant Peter Nicklas Hiebler
(b) Address 340 E. 22nd St, Balt-18, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/22/47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location a.a.Co. Md.

18 (a) Funeral director William Cook
(b) Address 1217 St. Paul St

19 (a) MAY 21 1947 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 1947, at 2:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 1947 to May 20 1947, and that I last saw her alive on May 20 1947

Immediate cause of death	Duration
Shock	12 hours
Due to Sulfathiazole Sensitivity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy Multiple small hemorrhages

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm Winston Finkel, Jr M. D.
Address Union Memorial Hospital Date signed 5-20-47

VS 130

G51894 J1 - 95720

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G51894

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. If exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
I- 8- 22
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 325 N. Gay St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert McArdell

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8, 1877

8. AGE: Years	Months	Days	If less than one day
70	0	11	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Musician
11. Industry or business Self

FATHER
12. Name Francis McArdell
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Garvey
15. Birthplace Ireland

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/23/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

19 (a) MAY 21 1947 (Date registered) (b) Huntington Williams M.D. (Registrar) Registrar

VS 150

MEDICAL CERTIFICATION PM

20. DATE OF DEATH May 19 1947, at 2.40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 27 1945, to May 19 1947, and that I last saw h im alive on May 19 1947.

Immediate cause of death	Duration
Cardiac Failure	
Due to arteriosclerotic Cardiovascular dis.	
arteriosclerosis, Genl.	
Due to Hypertension C.V.D.	
Other Conditions Cerebral thrombosis, multiple	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edmund B. Beacham M. D.
Address Balto Cty Hosp Date signed 20 May 47

G51895

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G51895

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Sq. Hosp 09
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Mo.
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1504 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theodore Schroeder Jr.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Flossie Schroeder
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 5/8/78

8. AGE: Years 69 | Months 0 | Days 18 | If less than one day ____ hr. ____ min.

9. Birthplace Md. (Balto.)
(Town, county, and state)

10. Usual Occupation Laundry worker

11. Industry or business State Police — Pikesville

FATHER
12. Name Theodore Schroeder
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace —

16 (a) Informant Flossie Schroeder
(b) Address 1504 W. Fayette St

17 (a) Burial (b) Date thereof 5/22/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery St. Thomas (My Lady's Manor)
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

MAY 21 1947
(Date rec'd by registrar)

(b) [illegible] for Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1947 at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 1947 to May 19 1947 and that I last saw h.l.v. alive on May 19 1947

Immediate cause of death
Lobar pneumonia — Duration 5 days

Due to

Due to

Other Conditions Arteriosclerosis, gen. Arteriosclerotic Heart disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stanley B. Klymowicz
Address Franklin Sq. Hosp. Date signed 5/21/47

G51896 BK# 960956 CWK-110696

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

119a

G51896 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 Months

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2104 N. Howard Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Stokes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 3-1946

8. AGE: Years	Months	Days	If less than one day
	6	16	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Stokes
13. Birthplace North Carolina

MOTHER
14. Maiden Name Evelyn Johnson
15. Birthplace North Carolina

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-21-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md

18 (a) Funeral director Mrs Frances A Kennedy
(b) Address 548 W. Biddle St.

19 (a) 5/20/47 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH May 19- 1947, at 1:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 16 1947 to May 19 1947 and that I last saw h im alive on May 19 1947

Immediate cause of death: Cardiac Failure — Duration: 1 day?

Due to:

Due to:

Other Conditions: Diarrhea, Anemia — 1 week
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: Cardiac Failure

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Julian P. Griffin M. D.
Address Balt. City Hosps. Date signed 20 May 1947

G51897

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G51897

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 825 Druid Hill Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Parlee Green

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Married

6 (b) Name of husband or ~~wife~~ XXX Samuel Green
6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) July 9, 1919

8. AGE: Years	Months	Days	If less than one day
27	10	11	hr. min.

9. Birthplace South Carolina
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Hamlin Watson
13. Birthplace South Carolina

MOTHER
14. Maiden Name Flora Rice
15. Birthplace South Carolina

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (b) Date thereof 5-23-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Druid Hill Ave. & Gwynn Oak Ave.

18 (a) Funeral director Wm. Frazier H. Hamby
(b) Address 578 W. Biddle St.

19 5/21/47 Huntington Williams M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 1947, at 9:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 20 1947 to May 20 1947, and that I last saw her alive on May 20 1947.

Immediate cause of death	Duration
Cachexia	4 mo
due to carcinomatosis peritonei	
Due to carcinoma large bowel	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: March 27,1947 carcinoma
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work
(e) Means of injury
23. Signature Richardyne K. Eastman M. D.
Address Johns Hopkins Hospital Date signed 5-20-47

G51898 BALTIMORE CITY HEALTH DEPARTMENT G51898
Registered No.

CERTIFICATE OF DEATH 469

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland North Broadway
(b) Street address Church Home & Hosp
(c) Hospital or institution: Church Home & Hosp 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 W Lexington St.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME John Dues Schultz

3 (b) If veteran, name war: no

3 (c) Social Security Account No. —

4. Sex: Male ~~White~~

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 2-12-1864

8. AGE: Years	Months	Days	If less than one day
83	3	8	____ hr. ____ min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Alexander Schultz
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary E Myers
15. Birthplace Maryland

16 (a) Informant Charles H Schultz
(b) Address 1400 W Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 22-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location

18 (a) Funeral director Charles P Powell
(b) Address 2427 Edmondson Ave
(b) [illegible] Huntington Williams Mgr

(Signature of Local Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-20 1947, at 12:03 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-22 1947 to 5-20 1947, and that I last saw him alive on 5-19 1947.

Immediate cause of death	Duration
Pulmonary Oedema	?
Due to	
Due to	
Other Conditions Arteriosclerosis Aneurism Abdom Aorta	?

(Include pregnancy within 3 months of death)

Date of operation 5/16/47

Major findings of operation: Aneurism Aorta + Carcinoma Pancreas

of autopsy: Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Allen Moulton M. D.
Address Church Home Hosp Date signed 5/20/47

VS 150

BALTIMORE CITY HEALTH DEPARTMENT X ✓ Registered No. 051899

351899

CERTIFICATE OF DEATH 937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wolfe & Broadway
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Arbutus (If outside city or town limits, write RURAL and give town)
(d) Street No. 1767 Vogt Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME John Rogers

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Emma Rogers

6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) October 25, 1876

8. AGE: Years 70 | Months 6 | Days 25 | If less than one day ____ hr. ____ min.

9. Birthplace Haywood Co. N. C. (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business Farming

FATHER — 12. Name Robert Rogers

13. Birthplace Unknown

MOTHER — 14. Maiden Name Nancy Russell

15. Birthplace Unknown

16 (a) Informant Mrs. Emma Rogers

(b) Address 1767 Vogt Ave. Arbutus, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 22, 1947 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cemetery

Location Frederick Ave. Baltimore

18 (a) Funeral director Easton & Sons

(b) Address 608 Frederick Ave. Catonsville

MAY 21 1947 (Date rec'd by registrar) (b) [redacted]

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1947, at 1.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 16 1947 to May 19 1947 and that I last saw him alive on May 19 1947

Immediate cause of death: Cardiac Failure — Duration

Due to: Art. + H. HD — Duration

Due to: Generalized Arteriosclerosis — Duration

Other Conditions: Cerebral Vascular accident. — Duration

(Include pregnancy within 3 months of death) — Duration

Date of operation — Duration

Major findings of operation: — Duration

of autopsy: — Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sidney Green M.D.
Address Sinai Hosp. Date signed 5/19/47

VS 150

X

G51900

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

G51900 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not estimate age or date of birth unless absolutely necessary, but in such cases write the words "Supposed" or "Estimated." Be sure to give the full name of deceased, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1619 Aliceanna Street
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME RALPH F. SMITH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1907

8. AGE: Years	Months	Days	If less than one day
40	3	18	hr. min.

9. Birthplace Bridgeton, N.J.
(Town, county, and state)
10. Usual Occupation Seaman
11. Industry or business Merchant Marine

FATHER
12. Name Linwood Smith
13. Birthplace ?

MOTHER
14. Maiden Name Caroline ?
15. Birthplace ?

16 (a) Informant Evelyn Czaplinski
(b) Address 632 South Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-24-47 (month) (day) (year)
(c) Cemetery or crematory.....
Location SALEM NEW JERSEY
18 (a) Funeral director George A. Weber
(b) Address 705 S. Conn at
19 (a) MAY 21 1947 (b) Burlington, Williamstown, N.J.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20, 1947 at 3:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of chest

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-20-47 at 2:45 A. M.
(b) Where did injury occur? 1619 Aliceanna Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearms

23. Signature Earl Royer M.D.
Medical Examiner.
Date signed 5/20/47

VS 181

G51901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G51901 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15-14 Division St.
(c) Hospital or institution: President Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2841 Remington Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Katie J. Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Married

6 (b) Name of husband ~~or wife~~ Edward Moore
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16 1886

8. AGE: Years	Months	Days	If less than one day
61	1	-	hr. min.

9. Birthplace Eastern Shore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Hopkins
13. Birthplace Md.

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Jamie E. Moore
(b) Address 2841 Remington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/21/47 (month) (day) (year)
(c) Cemetery or crematory Western Star
Location Baltimore, Md.

18 (a) Funeral director Mrs. Ida Bailey
(b) Address 1421 E. Jefferson St.

19 MAY 21 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 350

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16th 1947, at 8:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 9 1947 to May 16 1947, and that I last saw her alive on May 16th 1947.

Immediate cause of death Uremia — Duration

Due to Hypertensive Cardio-Vascular Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Nephroselerosis, Congestive

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Percival C. Smith M. D.
Address 15-14 Division St. Date signed 5-19-47

X

51902

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 176

G51902
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1626 McElderry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Laurence E. Phillips

3 (b) If veteran, name war

3 (c) Social Security Account No:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 27 1930

8. AGE: Years	Months	Days	If less than one day
17	3	20	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Industrial Laundry

FATHER
12. Name Albert P. Phillips
13. Birthplace Smithfield, Va

MOTHER
14. Maiden Name Ella McLeamins
15. Birthplace Baltimore, Maryland

16 (a) Informant Ella Phillips
(b) Address 1626 McElderry st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/22/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Baltimore, Md

18 (a) Funeral director Mrs. Ida Bailey
(b) Address 1421 E. Jefferson st

(c) MAY 21 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16, 1947, at 3:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Cervical Vertebrae
" Clavicle & Scapula

Due to

Other Conditions Severe congestion of all viscera

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 5/16/47 at 3:45 P.M.
(b) Where did injury occur? Industrial Laundry Chester & Oliver Sts
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Caught in a Washing Machine

23. Signature Thomas J. Mullen M.D. Medical Examiner.

Date signed 5/17/47

X.

C51903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 97

Registered No. C51903

CWK-76679

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 16-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 436 Hopewell Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Walker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife William Walker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 7- 71

8. AGE: Years 75 Months ? 5 Days ? 12 If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Sylvester Hill
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah ?
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/21/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location E. F. Co. Md

18 (a) Funeral director Metropolitan Funeral Home
(b) Address 924 N. Mount St.

MAY 21 1947
(Date rec'd by Registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1947, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 11 1942, to May 19 1947, and that I last saw her alive on May 19 1947

Immediate cause of death: Arteriosclerosis, advanced — Duration: Yrs

Due to: Malnutrition Dehydration.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same as above.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edmund B. Degraham M. D.

Address Balto City Hosp Date signed May 20, 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G51904

CWK-109795

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G51904

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1m 8d
(e) Length of stay in Baltimore (yrs., mos., or days) 9 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4233 Nicholas Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa Puccia

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Vincent Puccia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 2-1856

8. AGE: Years	Months	Days	If less than one day
90	9	17	hr. min.

9. Birthplace Italy
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Vincent Spalina
13. Birthplace Italy

MOTHER
14. Maiden Name Lena ?
15. Birthplace Italy

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 5/22/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Pk.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAY 21 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19-1947 19..., at 1:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 11 1947, to May 19 1947, and that I last saw her alive on May 19 1947.

Immediate cause of death: Bronchopneumonia — Duration 4 days

Due to: a. Fracture mid 1/3 right femur

Due to: b. Cardiac

Other Conditions: c. Generalized arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation 4/16/47

Major findings of operation: Fracture mid 1/3 right femur.

If autopsy: Bronchopneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 26/2
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 4/16/47 at 11:00 P.M.
(c) Where did injury occur Baltimore, Baltimore, Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? not
(Specify type of place)
(e) Means of injury Slipped & fell in bedroom.

23. Signature H. J. Tibby M.D.
Address Baltimore City Hosp. Date signed 5/20/47

Certificate subject approval of Medical Examiner
Howard J. Madden, M.D.

51905

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 948

C51905 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians:- please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3328 Elmley Avenue
(c) Hospital or institution: - - - - - - -
(d) Length of stay in hospital or inst. (yrs., mos., or days) - -
(e) Length of stay in Baltimore (yrs., mos., or days) Unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County - - -
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3328 Elmley Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country - - - -

3 (a) FULL NAME Samuel B. Woodward

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Carrie M. Menzel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4 - 17 - 1892

8. AGE: Years	Months	Days	If less than one day
55	1	2	- hr. - min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Wholesale Dealer
11. Industry or business Oil

FATHER
12. Name Joseph R. Woodward
13. Birthplace Virginia

MOTHER
14. Maiden Name Fannie E. Harris
15. Birthplace Virginia

16 (a) Informant Wife - Carrie M. Menzel
(b) Address 3328 Elmley Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-22-1947 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Taylor Avenue

18 (a) Funeral director Lilly & Zeiler, Inc.
(b) Address 403 South Wolfe Street

19 MAY 21 1947 (Date rec'd by registrar) Hampton Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19, 1947, at 5 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-17-1947 to 5-19-1947 and that I last saw h. alive on 5/19/1947

Immediate cause of death: acute Angina Pectoris — Duration: One day

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Fred Rinzler M. D.
Address 600 N. Dulaney Date signed 5-22-47

C51906

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

Registered No. C51906

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3612 Park Heights ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Heyison

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Rose
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1863

8. AGE: Years: 84 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Russia (town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Max Heyison
(b) Address 1800 Ruxton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-22-47 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Fernwood Hill Rd

18 (a) Funeral director Jack Lewis Inc
(b) Address 1435 E. Baltimore St.

19 (a) 5/21/47 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21, 1947 at 1:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 20 1947 to May 21 1947. and that I last saw h[illegible] alive on May 20 47.

Immediate cause of death Uremia — Duration

Due to

Due to

Other Conditions Left Pneumonia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice J. Citak M.D.
Address Sinai Hospital Date signed 5/21/47

G51907

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1476

Registered No. G51907

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2844 Boarman Ave
(c) Hospital or institution: 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2844 Bowman Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Berman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Fannie

6 (c) If above, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years	Months	Days	If less than one day
73			hr. min.

9. Birthplace Russia (Town, county and state)

10. Usual Occupation Jeweler

11. Industry or business

FATHER 12. Name Harry

13. Birthplace Russia

MOTHER 14. Maiden Name Annie

15. Birthplace Russia

16 (a) Informant Wife

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-21-47 (month) (day) (year)

(c) Cemetery or crematory Herring Run

Location Phila. Pa.

18 (a) Funeral director Jack Lewis Inc

(b) Address 1439 E. Baltimore St.

(a) (Date rec'd by registrar) MAY 21 1947 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/20/47 19 ... at 10 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1940 to 5/20 1947.
and that I last saw h[illegible] alive on 5/18 1947.

Immediate cause of death	Duration
Acute Cardiac Dilatation	
Due to Cardiac Hypertrophy with decompensation	2 yr
Due to	
Other Conditions Carcinoma of Ileum	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Zeidman M. D.

Address 2318 E. Fayette St. Date signed 5/21/47

X

G51908

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G51908

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. If unknown, write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 4 yes
(b) Street address BELVEDERE & GREENSTreet
(c) Hospital or institution:
LEVINDALE
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Levindale Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME IDA LAZARUS Lazarus

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Late Jacob
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1857

8. AGE: Years	Months	Days	If less than one day
90			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Israel Itzkowitz
13. Birthplace Russia

MOTHER
14. Maiden Name Bessie ?
15. Birthplace Russia

16 (a) Informant Harry Lazarus
(b) Address 3404 Dupont Ave

17 (a) Burial (b) Date thereof May 22, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bnai Israel Cem
Location Southern Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

MAY 21 1947 (b) Hampton Williams
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 1947, at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-15 1946 to 5-20 1947 and that I last saw h[illegible] alive on 5-20 1947

Immediate cause of death	Duration
1 hypertension	
2 Cerebral Arteriosclerosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Edmund Levin
Address Levindale Date signed 5/20/47

X

G51909

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G51909 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2430 Jefferson St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2430 Jefferson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Constantine Scheuring

3 (b) If veteran, name war	3 (c) Social Security Account No.
---	---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Pankratz Scheuring
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14, 1872

8. AGE: Years	Months	Days	If less than one day
74	8	6	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER 12. Name Franz Hofmann
13. Birthplace Germany

MOTHER 14. Maiden Name Barbara---
15. Birthplace Germany

16 (a) Informant Elsie Shipley
(b) Address 2430 Jefferson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 23/47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem.
Location Balto. Md.

18 (a) Funeral director Chilpo Henry Sons
(b) Address 2024 Orleans St.

MAY 21 1947 (Date received by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20/47 19 , at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/28 1946 to 5/20 1947 and that I last saw h[illegible] alive on 5/20 1947.

Immediate cause of death	Duration
Hypertensive cardiovascular renal disease, arteriosclerosis	2 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 617 Holford Rd Date signed 5/21/47 M. D.

X

G51910

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G51910

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bon SeCours Hosp.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3526 Frederick Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Hester - Pearl Elizabeth (Pearl E. Huster)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 6/ 1890

8. AGE: Years	Months	Days	If less than one day
56	9	14	hr. min.

9. Birthplace Maryland, Balto. (Town, county, and state)

10. Usual Occupation Secy. to Dr. Gundry

11. Industry or business

FATHER
12. Name Joseph E. Huster
13. Birthplace Balto. Maryland

MOTHER
14. Maiden Name Wilhelmina Weber
15. Birthplace Balto. Maryland

16 (a) Informant Marie Huster
(b) Address 3526 Frederick Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/ 23/ 37 (month) (day) (year)

(c) Cemetery or crematory [illegible]
Location Edmondson ave.

18 (a) Funeral director John D. Mitchell & Son
(b) Address 1300 Eutaw Place Balto. Md.

19 (a) [illegible] for Williams MD
(b) [illegible]

MAY 24 1937

FB 180

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 1937, at 6 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 19 37, to May 20 19 37, and that I last saw h[illegible] alive on May 20 19 37.

Immediate cause of death	Duration
Cardiac failure	
Due to hypertension and hypertrophic cardio-vascular disease.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James Aldwards.
Address Bon Secours Hosp. Date signed M. D. 5/ 24/ 37

X

G51911

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

✓ G51911 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1204 W. Cross St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1204 W. Cross St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis J. Gambos

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Hadya F.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 25 - 1895

8. AGE: Years	Months	Days	If less than one day
51	8	25	hr. min.

9. Birthplace Bermata, Turkey.
(Town, county, and state)
10. Usual Occupation Det
11. Industry or business Self

FATHER
12. Name Anthony Gambos
13. Birthplace Turkey

MOTHER
14. Maiden Name Anthony
15. Birthplace Turkey

16 (a) Informant Mrs. Hadya F. Gambos
(b) Address 1204 W. Cross St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/23/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Memorial Park
Location 3310 Taylor Ave

18 (a) Funeral director Jos. F. Conway & Son
(b) Address 901 W. Baltimore St.

19 (a) MAY 21 1947 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20, 1947 at 10.10 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Coronary occlusion
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D. Medical Examiner
Date signed 5-20-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 191

X

G51912

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 737

Registered No. G51912

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 549 Roberts St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Celia Matthews

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	married

6 (b) Name of husband or wife Wellington
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-3-1907

8. AGE: Years	Months	Days	If less than one day
40	2	17	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Theodore West
13. Birthplace Md.

MOTHER
14. Maiden Name Mattie Gray
15. Birthplace Md

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address Reuor

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/23/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. B. Kelson
(b) Address 1303 Presstman St

MAY 21 1947 (b) Washington Ave Nottingham Md
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH May - 20 1947, at 2.40 M

21. I certify that death occurred on the date above stated; that I attended deceased from May-19 1947 to May-20 1947, and that I last saw h[illegible] alive on May-20 1947.

Immediate cause of death	Duration
Hemolytic anemia acquired ? due to cold autohemagglutination	7-8 months
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert C. Austrian M.D.
Address The Johns Hopkins Hosp. Date signed 20 May 47

C51913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

CWK-104826

Registered No. C51913

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7- 22-
(e) Length of stay in Baltimore (yrs., mos., or days) Ent. 17 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2015 Llewellyn Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jake Braboy

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-12-644

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Cora
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7-1907

8. AGE: Years	Months	Days	If less than one day
40	2	18	hr. min.

9. Birthplace South Carolina (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William Braboy
13. Birthplace South Carolina

MOTHER
14. Maiden Name Susanne Lee
15. Birthplace South Carolina

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 23/947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cmty
Location A C Co Md

18 (a) Funeral director Robert Biddison
(b) Address 15-15 McElderry St
MAY 21 1947 (Date received by Registrar) (b) Washington Blvd

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19- 19 47 at 10:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 27 19 46 to May 19 19 47 and that I last saw h. alive on May 19 19 47.

Immediate cause of death	Duration
Tuberculous Polyserositis	1 yr. (?)
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Refused

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Hunt M. D.
Address Balt. City Hosp. Date signed 5-20-47

1914

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G51914

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6 Stuart Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LUTIE FOREMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Wm B. Foreman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4-1877

8. AGE: Years 70 | Months | Days 15 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business at Home

FATHER 12. Name Wm B Foreman

13. Birthplace Va

MOTHER 14. Maiden Name Unk

15. Birthplace

16 (a) Informant Mary Ellen Foreman

(b) Address 6 N. Stuart Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 22-47 (month) (day) (year)

(c) Cemetery or crematory Wm Lucas

Location Taylor Ave

18 (a) Funeral director John B Connelly

(b) Address 418 Easton Ave, Catonsville

19 MAY 21 1947 Connelly for Williams Mgr

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19, 1947, at 3.20 a M

21. I certify that I took charge of the remains described above, held an insp.& inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cirrhosis of liver.

Due to

Other Conditions Lacerated wound of scalp.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury 5/19/47 at about 3 a. M.
(b) Where did injury occur? Stuart Ave Garage
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fall

23. Signature Earl K Hayes M.D.
Medical Examiner.
Date signed 5-19-47

VS 151

X

G51915 ✓ G51915

CWK-107831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Registered No. 12 12

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-27-26
(e) Length of stay in Baltimore (yrs., mos., or days) 35 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4940 Eastern Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie W Harges

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Ernest

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 4-1892

8. AGE: Years	Months	Days	If less than one day
54	9	15	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wilson
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Fisher
15. Birthplace Virginia

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 23 47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A.A. Co. Md

18 (a) Funeral director Isaac L. Brown Son
(b) Address 1016 W. Montgomery St.

MAY 21 1947 (Date received by registrar) Huntington Williams

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH May 19 19 47 at 1:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 22 19 47, to May 19 19 47, and that I last saw her alive on May 19 19 47.

	Duration
Immediate cause of death Hypostatic Lobar Pneumonia LLL	1-3 days
Due to Cachexia - Emaciation	4 Mo
Due to Ca. Body & Tail of Pancreas 2yr c Widespread Intraperitoneal Metastases	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 2-20-47
Major findings of operation: Carcinomatosis
of autopsy: At abdomen

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R Lawler

Address City Hosp Date signed 5-20 47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51916

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G51916 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Charles + 34th
(c) Hospital or institution: Gruenmoy Apts
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Charles + 34th St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Eugene A Blair

3 (b) If veteran, name war: W
3 (c) Social Security Account No. none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Lyla S.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 29 1862

8. AGE: Years 85 | Months 1 | Days 21 | If less than one day ____hr. ____min.

9. Birthplace Baltimore Md (Town, county, and State)

10. Usual Occupation Insurance Broker

11. Industry or business

FATHER
12. Name Charles E Blair
13. Birthplace Snow Hill Md

MOTHER
14. Maiden Name Frances J Mitchell
15. Birthplace Baltimore Md

16 (a) Informant Eugene A Blair
(b) Address Gruenmoy Apts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/23/47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Wilson Funeral Home
(b) Address 1217 E Fort Ave

MAY 21 1947 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1944 to May 20 1947 and that I last saw h[illegible] alive on 5/20 1947.

Immediate cause of death	Duration
Coronary Occlusion	3 Hours
Due to Arteriosclerosis (Uncomplicated)	10 Years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Clayton Hemfinger

Address 3 E Madison St Date signed M. D. 5/22/47

Clayton Hemfinger MD

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

GM G51917 110766

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46F G51917 Registered No.

MAY 21 1947

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 6-½ Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 717 S. Bond ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morgan Iva

3 (b) If veteran, name war	3 (c) Social Security Account No.
/	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Willard Morgan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21 -1894

8. AGE: Years	Months	Days	If less than one day
52	11	29	hr. min.

9. Birthplace Penna. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Dailey
13. Birthplace Penna.

MOTHER
14. Maiden Name Little
15. Birthplace Penna.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 5/21/47 (month) (day) (year)
(burial, cremation, or removal)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

1947 (Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION 12 Noon

20. DATE OF DEATH May 20 - 1947, at ~~12:20 PM~~

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 - 1947, to May 20 - 1947, and that I last saw h or alive on ay 20 - 1947

Immediate cause of death	Duration
Respiratory failure	
Due to Acute pulmonary edema	
Due to	
Other Conditions Diabetes Mellitus & acidosis. Shock.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Doyle Waldron M. D.
Address B C H Date signed 5/21/47

G51918 BALTIMORE CITY HEALTH DEPARTMENT ✓ G51918
Registered No.

CERTIFICATE OF DEATH 93a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1730 W. Lexington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1730 W. Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Henry Robinson
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M Fem
5. Color or race Col
6 (a) Single, married, widowed, or divorced. married
6 (b) Name of husband or wife Launa
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1887
8. AGE: Years 60 | Months | Days | If less than one day hr. min.
9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER 12. Name Henry Robinson
13. Birthplace Va.

MOTHER 14. Maiden Name Susanda
15. Birthplace Va.

16 (a) Informant Mrs. Estelle Lawrence
(b) Address 1730 W. Lexington St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-21-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winans
18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 3224 N. Calvert St.
19 (a) MAY 21 1947 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-17- 1947, at 12 45 M
21. I certify that death occurred on the date above stated; that I attended deceased from 5/2/47 19 to 5/16/47 19, and that I last saw h. alive on 5/16/47 19.

Immediate cause of death	Duration
Acute hypodermic	2 days
Due to Hypertension	unknown
Due to Uraemia	unknown
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature W. B. Owen
Address 401 Edmondson Date signed 5/21/47

G51919

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G51919 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1707 DUKELAND St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1707 DUKELAND St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Timothy J. DEE

3 (b) If veteran, name war NONE

3 (c) Social Security Account No.

4. Sex MALE

5. Color or race White

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife MILDRED A. DEE

6 (c) If living, give age 46 years

7. Birth date of deceased (mo., day, yr.) JULY 8 - 1899

8. AGE: Years 47 | Months 10 | Days 11 | If less than one day ____ hr. ____ min.

9. Birthplace BALTIMORE Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name MICHAEL DEE
13. Birthplace IRELAND

MOTHER
14. Maiden Name CATHERINE BARRETT
15. Birthplace IRELAND

16 (a) Informant MILDRED A. DEE
(b) Address 1707 DUKELAND St

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAY 13-1947 (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location BALTIMORE Md

18 (a) Funeral director Lt Col B.M. Walter
(b) Address Pratt & Stricker St

19 (a) 1947 (b) [illegible] (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 19 1947, at 9.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1943 to May 19 1947.
and that I last saw him alive on May 19th 47.

Immediate cause of death

(a) Coronary Occlusion

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation ✓

of autopsy none

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? ✓
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ While at work?
(Specify type of place)
(e) Means of injury ✓

23. Signature [illegible]

Address 121 Poplar Grove St Date signed 5/21/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51920

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G51920

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3002 W. Cold Spring Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3002 W. Cold Spring Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucy Cary Hiner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 3 1876

8. AGE: Years	Months	Days	If less than one day
71	5	17	hr. min.

9. Birthplace Thorn Pendleton Co. W. Virginia
(Town, county, and state)

10. Usual Occupation Teacher in Public School

11. Industry or business

FATHER
12. Name Benjamin Hiner
13. Birthplace Thorn Pendleton Co. W. Va

MOTHER
14. Maiden Name Mary Ann Hansel
15. Birthplace Thorn Pendleton Co W. Va

16 (a) Informant Bertie H. Hiner
(b) Address 3002 W. Cold Spring Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 22, 1947 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location Baltimore Md.

18 (a) Funeral director Henry W. Jenkins & Son
(b) Address McCulloh & Richard St. Balto

19 (a) (Date rec'd by registrar) (b) Registrar

MAY 21 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 1947, at 4:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1947 to May 19 1947, and that I last saw her alive on May 19 1947.

Immediate cause of death	Duration
Cerebral Hem Embolism	5 days
Due to	
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
(f) Signature Thos Duley Thomas M. D.
Address 614 Med arts Bldg Date signed May 21 1947

Verified by Williams, MD

X

G51921

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G51921 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 425 Hutchins ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 425 Hutchins ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Gibbs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5-1867

8. AGE: Years: 80 | Months: - | Days: 15 | If less than one day: hr. min.

9. Birthplace N. Carolina (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Coun Watts
13. Birthplace N.C

MOTHER
14. Maiden Name Mary Watts
15. Birthplace N C

16 (a) Informant Mrs Rosa Cunningham
(b) Address 425 Hutchins ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-23-47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary.
Location R. I. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E Preston St

(a) Date received (Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1947, to May 1947 and that I last saw h[illegible] alive on May 19 1947

Immediate cause of death: Clinical Intestinal Neoplasm — Duration: 4 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.

Address 2329 Guilford Ave Date signed May 21 1947

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51922

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

G51922 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1425 W. Mulberry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Wade Jr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age 19 years

7. Birth date of deceased (mo., day, yr.) 1928

8. AGE: Years	Months	Days	If less than one day
19			hr. min.

9. Birthplace Dinwoodie — Va
(Town, county, and state)

10. Usual Occupation Truck Driver

11. Industry or business

FATHER 12. Name John Wade

13. Birthplace Va

MOTHER 14. Maiden Name Jessie Jones

15. Birthplace Richmond — Va

16 (a) Informant Mrs. Jessie Wade

(b) Address 1425 W. Mulberry St

17 (a) Burial (b) Date thereof 5-22-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Carbuthus

Location Carbuthus — Md

18 (a) Funeral director Mrs. Katie R. Williams

(b) Address 322 N. Schroeder St.

19 (a) (b)

Registered by

MAY 21 1947

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1947 at 9 20 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Generalized Peritonitis

Due to Gunshot Wound of Abdomen - Laceration of Stomach, Intestines & Colon

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-17-47 at 11:45 P M.
(b) Where did injury occur? 1425 W. Mulberry St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Firearms

23. Signature Earl L. Gross M.D.
Medical Examiner.
Date signed 5-19-47

X

G51923

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131B G51923 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 17th Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1703 St. Paul St (if rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Claude Fountain

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Perha

6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) March 28 1904 (1905)

8. AGE: Years 42(43) | Months 1 | Days 27 | If less than one day hr. min.

9. Birthplace S. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Less Fountain

13. Birthplace S. C.

MOTHER 14. Maiden Name Nettie Jones

15. Birthplace S. C.

16 (a) Informant JOHNS HOPKINS HOSPITAL Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-22-47 (month) (day) (year)

(c) Cemetery or crematory Hartsville

Location South Carolina

18 (a) Funeral director Mrs. Katie R. Williams

(b) Address 323 N. Schroeder St.

19 (a) MAY 21 1947 (Date rec'd by registrar) (b)

Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1947, at 11:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1947 to May 19 1947, and that I last saw h living alive on May 19 1947

	Duration
Immediate cause of death: Uremia	4 hrs.
Due to: Chronic glomerulo-nephritis	4 yrs.
Due to:	
Other Conditions: Hypertension heart disease	4 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ira Henderson M.D.

Address 321 N. Date signed 5/19/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age is especially important. Physicians; please write the causes of death clearly and legibly.

G51924

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G51924 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 mos
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 645 W. Mulberry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles Johnson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Ella Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1858

8. AGE: Years 89 | Months — | Days — | If less than one day hr. — min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Unemployed
11. Industry or business

FATHER 12. Name Elijah Johnson
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Catherine Willis Johnson
15. Birthplace West River — Md

16 (a) Informant Mrs. Ella Johnson
(b) Address 645 W. Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-22-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winans

18 (a) Funeral director Wm. Katie & Wilhelm
(b) Address 322 N. Schroeder St.

19 (a) MAY 21 1947 (Date received by registrar) (b) Timothy Fin Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1947, at 12 22 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1947 to May 18 1947, and that I last saw him alive on May 15 1947.

Immediate cause of death	Duration
Acute Pulmonary Edema	
Due to Arteriosclerotic heart disease	
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert E. McCord M.D.
M. D.
Address Redwood & Greene Date signed 5-21-47

G51925

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G51925

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1307 Harlem Ave
(c) Hospital or institution
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1307 Harlem Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Jane Smith
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4, 1864

8. AGE: Years	Months	Days	If less than one day hr.	min.
73	1	15		

1874

9. Birthplace Westmoreland Co. Va. (Town, county, and state)
10. Usual Occupation housework
11. Industry or business None

FATHER
12. Name James Smith
13. Birthplace Virginia

MOTHER
14. Maiden Name Priscilla Montague
15. Birthplace Eastern Shore, Maryland

16 (a) Informant Harriet Campbell
(b) Address 718 Grand St, Hoboken, N.J.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-21-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winans

18 (a) Funeral director Mrs. Lettie R Williams
(b) Address 322 N. Schroeder St.

19 (a) Date received MAY 21 1947 (b) Registrar Huntington Williams Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1947, at 6:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-4 1947, to 5-19 1947, and that I last saw h[er] alive on May 19, 1947

Immediate cause of death myocardial insufficiency — Duration 2 mos
Due to myocarditis — 14 yrs
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John E. S. Camper M. D.
Address 639 N. Carey St Date signed 5-20-47

X

Rev.—3-13-39—L. F. 2.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

G51926

CERTIFICATE OF DEATH

3 √45a G51926

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2808 Guilford Ave ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Richard Amrein

(a) RESIDENCE NO. 2808 Guilford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine R. Amrein

6 DATE OF BIRTH (month, day, and year) Mar. 18, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	73	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co. (State or country) Md.

PARENTS

10 NAME OF FATHER William Amrein

11 BIRTHPLACE OF FATHER (city or town) Balto. Co. (State or country) Md.

12 MAIDEN NAME OF MOTHER Justine Wilhelm

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Arthur R. Amrein

(Address) 2808 Guilford Ave.

15 MAY 21 1947 [signature]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1947

17 I HEREBY CERTIFY, That I attended deceased from Feb, 1947, to May 21, 1947, that I last saw h. alive on May 20, 1947 and that death occurred, on the date stated above, at 1.45 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma - Lower Lip

(duration) 3 yrs + mos. ds.

CONTRIBUTORY Metastases Ca-Neck

(Secondary)

+ Bronchial (duration) yrs 3 mos. + ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 1944

Was there an autopsy? No

What test confirmed diagnosis? Clinical - Tissue

(Signed) F. V. D. Mack, M. D.

, 19 (Address) 513 E. 39th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Memorial Park Cemetery	May 23 19 47
20 UNDERTAKER	ADDRESS
Lasvahn Funeral Home	7401 Belair Rd.

Important. See instructions on back of certificates.

G51927 BC# B 52767

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1190

G51927 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1311 James Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1311 James Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pauline Lyk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30 1946

8. AGE: Years	Months	Days	If less than one day
	9	20	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Edward Lyk
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Laura Blaszak
15. Birthplace Balto. Md.

16 (a) Informant Edward Lyk
(b) Address 1311 James Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/22/47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County
18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street
19 (a) (Date received by registrar) (b) Registrar

JUN 23 1947

MEDICAL CERTIFICATION 420

20. DATE OF DEATH May 20 1947 at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 19, 1947 to May 20 1947 and that I last saw h alive on 19

Immediate cause of death Acute Entero-Colitis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Andrew Lukaroski M. D.
Address 20-29 Eastern Ave. Date signed

X

G51928

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G51928 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3005 Ellerslie Ave (Dor)
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3005 Ellerslie Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Kinnear

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Cora L. Kinnear (nee Caffey) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 13, (1877) 1879

8. AGE: Years	Months	Days	If less than one day
(70) 68	4	8	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business Acme Steel Co.

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Lora E. Canby
(b) Address 2919 White Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/24/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

MAY 21 1947 (Date filed by Registrar) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/21 1947 at 4:45 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions Arteriosclerotic C.V Disease
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Schrade M.D.
Medical Examiner.
Date signed 5/21/47

G51929

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G51929 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1257 Battery Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herman Schoberg.

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-09-0249

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Rose-
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-2-1867

8. AGE: Years	Months	Days	If less than one day
69	4	19	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation PENSION
11. Industry or business B+ORR

FATHER	12. Name Herman Schoberg
	13. Birthplace Germany.
MOTHER	14. Maiden Name THERESA TROCKAMP
	15. Birthplace GERMANY

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address Records

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAY-24-1937 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A a Co.

18 (a) Funeral director Bernard C Hart
(b) Address 121 E West St

19 (a) MAY 24 1937 (Date received by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May-21-1937, at 4.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May-21 1937, to May-21 1937, and that I last saw him alive on May-21 1937.

Immediate cause of death	Duration
Pulmonary edema due to arteriosclerotic heart disease + old type cardiac	
Due to Infarction	7 days
Due to	
Other Conditions Right hemiplegia - due to softening Left temp. cortex (Include pregnancy within 3 months of death)	? 6 mo's

Date of operation
Major findings of operation:
of autopsy? As Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Eugene Luger M.D.
Address Hopkins Hosp Date signed May 24 1937

Johns Hopkins Hosp
Howard J. Curtis, M.D.

G51930 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G51930

CERTIFICATE OF DEATH

180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wash. St. & Bulford Ave.
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Aberdeen
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Haig Balajikian

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Haig Balajikian

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23, 1894

8. AGE: Years 53 | Months 2 | Days 26 | If less than one day ____ hr. ____ min.

9. Birthplace —, Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER — 12. Name Samuel Jay

13. Birthplace Maryland

MOTHER — 14. Maiden Name Annie Davis

15. Birthplace Maryland

16 (a) Informant Hospital Records

(b) Address 33rd St. & Bulford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 24-47 (month) (day) (year)

(c) Cemetery or crematory Spesutia

Location Perryman Md.

18 (a) Funeral director Henry Fanning Sons

(b) Address Aberdeen Md.

19 (a) May 1947 (Date filed by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21, 1947, at 9:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15, 1947 to May 21, 1947 and that I last saw h.. alive on May 21, 1947

Immediate cause of death: Bronchopneumonia — Duration: 2 days

Due to: Burns of trunk & branches — 6 days

Due to:

Other Conditions: 2nd. & 3rd. degree burns of face, shoulders, & arms — 6 days
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident (fire)
(b) Date of occurrence May 14, 1947 at 11:30 P M
(c) Where did injury occur? Aberdeen (City or town) Harford (County) Md. (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury: Burns (Conflagration) 9 P.M.

23. Signature Edward H. Jones

Address Union Memorial Hosp. Date signed 5-21-47

Howard J. Andreas, M.D.

651931

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

651931 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 822 N. Carrollton Ave.
(c) Hospital or institution:
N. M. Carroll Home for the Aged
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 822 N. Carrollton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELLEN G. JOHNSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 25, 1860

8. AGE: Years	Months	Days	If less than one day
86	8	26	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Maid in Home

11. Industry or business

FATHER
12. Name
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Johnson
15. Birthplace Md.

16 (a) Informant Miss Rosa Stewart
(b) Address 822 N. Carrollton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-24-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

MAY 22 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 20 1947 at 6:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from MAY 1, 1947, to MAY 19, 1947, and that I last saw her alive on MAY 19, 1947.

Immediate cause of death ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE — Duration 1 yr or more

Due to GENERALIZED ARTERIOSCLEROSIS

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas W. Davis, Jr. M. D.
Address 1824 W. Franklin St. Date signed 6-20-47

X

G51932

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 132a

Registered No. G51932

GM 110778

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 12 N. Stricker ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Williams, Gladys

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 13 - 1918

8. AGE: Years	Months	Days	If less than one day
28	9	7	hr. min.

9. Birthplace MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward Lyles
13. Birthplace ?

MOTHER
14. Maiden Name Mattha Coles
15. Birthplace VA.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 5/23/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. F. Co. Md.

18 (a) Funeral director Metropolitan Funeral Homs Inc.
(b) Address 921 N. Mount St.

19 (a) MAY 22 19 47 [illegible] Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 - 1947, at 11.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 1947, to May 20 1947, and that I last saw her alive on May 20 1947.

Immediate cause of death	Duration
Marked pyelonephritis	
Due to	
Due to	
Other Conditions Cerebral edema	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Marked pyelonephritis Cerebral edema

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Dayle Wolcott M.D.

Address B. C. H. Date signed 5/21/47

VS 150

G51933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

106 B

Registered No. G51933

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 632½ W. Franklin St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 632½ W. Franklin
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lawrence S. Cannatella

3 (b) If veteran, name war None.

3 (c) Social Security Account No. 217-14-2142

4. Sex M.

5. Color or race W.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife (Nara)

6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Apr. 5-1880.

8. AGE: Years 60 | Months 1 | Days 13 | If less than one day hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation Cook.

11. Industry or business

FATHER 12. Name Carmello S.

13. Birthplace Italy

MOTHER 14. Maiden Name Josephine Calcaterra

15. Birthplace Italy

16 (a) Informant Mary Cortera

(b) Address 632½ W. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-22-47 (month) (day) (year)

(c) Cemetery Holy Redeemer

Location Belgium Md.

18 (a) Funeral director Edward W. Lachenmeier

(b) Address 703 Fremont Ave

19 (a) MAY 22 1947 (Registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1947, at 1a M

21. I certify that death occurred on the date above stated; that I attended deceased from May 5 1947 to May 19 1947 and that I last saw h[illegible] alive on May 16 1947.

Immediate cause of death — Duration

Acute Dilatation of Heart.

Due to

Due to

Other Conditions Bronchial Asthma 2 yrs. & Chronic Bronchitis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. L. Lichtenberg M.D.

Address 708 E. North Ave Date signed 5/21/47

VS 150

X

G51934

BALTIMORE CITY HEALTH DEPARTMENT

GM. 105274 **CERTIFICATE OF DEATH** 1632 N. 13th St. Registered No. G51934

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: altimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 2 7-14 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1632 E. Monument ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Redmond . Gladys (Martha Gladys Redmond Waters)

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-12-0256

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1 1919

8. AGE: Years	Months	Days	If less than one day
28	4	16	hr. min.

9. Birthplace West Virginia (Town, county, and state)
10. Usual Occupation Stenographer
11. Industry or business

FATHER
12. Name Alex Redmond
13. Birthplace W. VA.

MOTHER
14. Maiden Name Arizona Randolph
15. Birthplace W. VA.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 22 1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Park
Location

18 (a) Funeral director Robert F. Cromwell
(b) Address 1216 W. Caroline St.

19 MAY 22 1947 Washington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1947, at 5.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 15 1946 to May 17 1947, and that I last saw her alive on May 17 1947.

Immediate cause of death: Pulmonary Tuberculosis — Duration 1 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: not obtained

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hellwright M. D.

Address Date signed 5/22/47

VS 150

G51935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1548

Registered No. G51935

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please correct age is especially important. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town).
(d) Street No. 284 W. Mulberry St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cora Wise (BLOXOM)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	N	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-11-1917

8. AGE: Years	Months	Days	If less than one day
30 29		9	hr. min.

9. Birthplace Columbia S.C. (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Henry Wacla
13. Birthplace S.C.

MOTHER
14. Maiden Name Victoria
15. Birthplace S.C.

16 (a) Informant John Wise
(b) Address 784 W. Mulberry St

17 (a) Final (b) Date thereof 5 23 47 (month) (day) (year)
(burial, cremation, or removal)
(c) Cemetery or crematory Mt. Calvary Cem
Location A. G. County Md

18 (a) Funeral director Gilligan & Jackson
(b) Address 1947 Pennsylvania ave

19 MAY 22 1947 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-20 1947, at 8 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-16 1947 to 5-20 1947 and that I last saw h[illegible] alive on 5-20 1947

Immediate cause of death	Septicemia	Duration
Due to	Abscess of mandible	
Due to	Infected tooth	
Other Conditions		

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature I. B. Higgins M. D.
Address Provident Hosp Date signed 5-21-47

VS 150

G51936

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

Registered No. G51936

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Cayuga & Dukeland
(c) Hospital or institution: West Baltimore Gen Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr 5 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 15

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3811 Lewin Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Michael Charles Engelmeyer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Angela Mary

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) July 1 - 1879

8. AGE: Years 67 | Months 10 | Days 19 | If less than one day hr. min.

9. Birthplace Balto - Md (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER 12. Name Wolfgang Engelmeier

13. Birthplace Md.

MOTHER 14. Maiden Name Clara Herring

15. Birthplace Md.

16 (a) Informant Mrs. Donald Engelmeyer

(b) Address 3811 Lewin Ave -

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/23/47 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Md.

18 (a) Funeral director Leonard J. Ruck

(b) Address 5305 Harford Rd

(Date received) MAY 22 1947 (Registrar's signature) Wilhelmina Williamson

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 May 1947, at 9:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 May 19 47 to 20 May 19 and that I last saw h/m alive on 20 May 19 47.

Immediate cause of death	Duration
Respiratory Failure	
Due to Cerebral Accident X (R. Sided Hemiplegia	
Due to Hypertension & C.V. Dis.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leslie A. Hall Jr. M. D.

Address 1 W. Baltimore Date signed 5/31/47

Gen Hosp. X

G51937 HEALTH DEPARTMENT—CITY OF BALTIMORE G51937

CERTIFICATE OF DEATH ✓95c

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2712 Strathmore St., Ave., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Lena W. DARNEY

If U.S. Veteran specify WAR

(a) Residence: No. 2712 STRATHMORE St., 27-3 Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	W	M

3a. If married, widowed, or divorced HUSBAND of (or) WIFE of Charles D.

6. DATE OF BIRTH (month, day, year) Jan. 31-1892

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
55	3 4	20	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. at home.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Md.

FATHER

13. NAME Christian Wohlgemuth

14. BIRTHPLACE (city or town) (State or country) Germany

MOTHER

15. MAIDEN NAME Margaret Gerlach

16. BIRTHPLACE (city or town) (State or country) Md.

17. INFORMANT Mr Charley Darney

(Address) 2712 Strathmore

18. BURIAL, CREMATION, OR REMOVAL

Place Moreland Pk. Date 5/22/ 19 47

19. UNDERTAKER Leonard Ruth.

(Address) 5305 Reisterstown Rd.

20. DATE RECEIVED MAY 22 1947 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) May 20, 1947

22. I HEREBY CERTIFY, That I attended deceased from Oct 19 46 to May 20 19 47

I last saw her alive on 5/20 19 47 Death is said to have occurred on the date stated above, at 12 45 m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
CARDIAC - HYPERTROPHY	1946
CARDIAC DECOMPENSATION	5/20/47
PULMONARY EDEMA	5/20/47

Other contributory causes of importance:

OSTEO - ARTHRITIS	10 Yrs

Was an operation performed? No Date of

For what disease or injury?

What test confirmed diagnosis? — Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur?

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) Walter E. Karfgin M. D.

(Address) 4231 Harford Ave.

Information should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WALTER E. KARFGIN, M.D. X

G51938

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 49a

Registered No. G51938

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital 27-14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 215 Woodlawn Rd. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Marion Richardson Dill

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife: —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/15/1876

8. AGE: Years	Months	Days	If less than one day
71	4	6	hr. min.

9. Birthplace Abingdon Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry F. Dill
13. Birthplace Abingdon, Md.

MOTHER
14. Maiden Name Fanny V. Bateman
15. Birthplace Abingdon Md.

16 (a) Informant Dr. Wm. Hall m.d.
(b) Address 215 Woodlawn Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/24/47 (month) (day) (year)
(c) Cemetery or crematory Emmorton, Md.
Location (Mt. Carmel)

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address

19 MAY 22 1947 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/21 1947, at 2.25 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/20 1947, to 5/21 1947, and that I last saw her alive on 5/21 1947.

Immediate cause of death	Duration
Resp. failure	
Due to Generalized carcinomatosis	
Due to Carcinoma of ovary	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature August Kiel
Address Mercy Hosp. Date signed 5-21-47 M. D.

VS 150

G51939

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G51939

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Linden + Madison St
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 27-10 5306 St George's St (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MABEL J. NORRIS

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Wm. B. Norris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6, 1879

8. AGE: Years	Months	Days	If less than one day
68	1	15	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Albert M. Bowen
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Julia Howell
15. Birthplace Balto., Md.

16 (a) Informant Mr. Herbert Norris
(b) Address 506 Chateau Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/24/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 MAY 22 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21st 1947 at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 5 1947 to May 21 1947, and that I last saw h[illegible] alive on May 21 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Cerebral Thrombosis	13 days
Due to A. C. V. Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature C.E. Gonzalez
Address Maryland Gen. Hosp. Date signed 5/21/47

VS 150

C51940

JL - 107557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V13B

Registered No. C51940

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 - 27 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2213 Essex St. - 31
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Lucille Kulisiewicz - [redacted]

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-18-6838

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Anthony D.
6 (c) If alive, give age 29 years

7. Birth date of deceased (mo., day, yr.) Oct. 18, 1918

8. AGE: Years	Months	Days	If less than one day
28	7	3	hr. min.

9. Birthplace New Jersey (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Michael Sikorra
13. Birthplace Poland

MOTHER
14. Maiden Name Julia Shober
15. Birthplace Poland

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/26/47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Gorsuch Mill Rd.

18 (a) Funeral director M. W. E. Dippel's Sons
(b) Address Lombard & Bond Sts.

19 (a) MAY 22 1947 (Date received by registrar) Huntington Williams M.D. (b)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 1947, at 10.50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 13 1947 to May 21 1947, and that I last saw h[illegible] alive on May 21 1947

Immediate cause of death: Pulmonary Tuberculosis, Far-advanced — Duration 5 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Refused

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wilhaim J. Hunt M. D.
Address Balt. City Hosp. Date signed 5-21-47

X

G51941

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 132

Registered No. G51941

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5614 Mattfeldt Ave.,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-15

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5614 Mattfeldt Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank K. Lucas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	Widower

6 (b) Name of husband or wife Georgetta Lucas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 22, 1857

8. AGE: Years	Months	Days	If less than one day
89 88	8	28	hr. min.

9. Birthplace Philadelphia, Pa.
(Town, county, and state)

10. Usual Occupation Retired Machinist

11. Industry or business Machine Shop

FATHER
12. Name William B. Lucas,
13. Birthplace Penna.

MOTHER
14. Maiden Name Knox,
15. Birthplace Penna.

16 (a) Informant Mrs. Flora Ensor,
(b) Address 5614 Mattfeldt Ave.,

17 (a) burial (b) Date thereof 5/23/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park,
Location Baltimore City,

18 (a) Funeral director L. Vernon Lemmon
(b) Address 4611 Park Heights Ave.

19 (a) MAY 22 1947 (b) Huntington Mills
(Date rec'd by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20, 1947 19 at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/7 19 43 to 5/20/ 1947, and that I last saw him alive on 5/20/ 19 47

Immediate cause of death

Coma

Due to Uremia

Due to Arteriosclerosis & old age

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
3 da.
1 yr.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sherwood Wentz M.D.
Address 2601 Manhattan Ave. Date signed 5/20/47

G51912

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 52a

Registered No. G51912

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Hamilton Sts
(c) Hospital or institution: Mercy Hospital 27-11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5006 York Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Brooks

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) Name of husband or wife Margaret Brooks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
77	7		hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Robert Brooks
13. Birthplace Maryland

MOTHER
14. Maiden Name Virginia McMullen
15. Birthplace Maryland

16 (a) Informant Rev. James H. Brooks
(b) Address 5006 York Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-23-47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location City

18 (a) Funeral director Wedgefield & Son
(b) Address Greenmount Ave & 22nd

19 MAY 22 1947 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1947, at 11:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-14 1947, to 5-14 1947, and that I last saw h[illegible] alive on 5-5 1947.

Immediate cause of death Shock — Duration

Due to Nephrectomy for malignancy left kidney

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 5-13-47
Major findings of operation: Malignant tumor - left kidney
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. G. Smith, M.D. M. D.
Address Mercy Hospital Date signed 5-14-47

VS 150

G51913

BCHD-73343 BALTIMORE CITY HEALTH DEPARTMENT 119a

CERTIFICATE OF DEATH

Registered No. G51913

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 727 N Eden St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10-2
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 727 N. Eden St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Leon Bowie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5 1947

8. AGE: Years	Months	Days	If less than one day
	2	15	hr. min.

9. Birthplace Balto City
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Bill Bowie
13. Birthplace Cynthiana S C

MOTHER
14. Maiden Name Johnnie Mae McClaire
15. Birthplace Rocky Pt. N C

16 (a) Informant Johnnie Mae Bowie
(b) Address 727 N. Eden St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 28 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location A & A Co Md

18 (a) Funeral director Robert E. Williams
(b) Address 1545 McCulloh St

19 MAY 22 1947 Huntingtown, Md
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 1947, at 5:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/15 1947 to 5/20 1947 and that I last saw him alive on 5/20 1947

Immediate cause of death
(a) Cholera Infantum 7 Days
Due to
(b) Rickets 2 mos
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. W. Blake M. D.
Address 1537 N. Central Ave Date signed 5/24/47

VS 150

G51911 BALTIMORE CITY HEALTH DEPARTMENT X G51911
BC#6-78259 CERTIFICATE OF DEATH V 157 M Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & John Sts.
(c) Hospital or institution: Hospital for the Women of Maryland.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 11 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna. (b) County Chester
(c) City or town Baltimore Oxford Pa
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Blackburn
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex M.
5. Color or race W
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 5/10/47
8. AGE: Years 0 Months 0 Days 11 If less than one day hr. min.
9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name Walter W. Blackburn
13. Birthplace Oxford Pa
MOTHER 14. Maiden Name Edith Ann Jackson
15. Birthplace Oxford Pa
16 (a) Informant Walter Blackburn
(b) Address Oxford Pa
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 13 1947 (month) (day) (year)
(c) Cemetery or crematory Oxford Cemetery
Location Oxford Pa
18 (a) Funeral director H. J. Rogers
(b) Address Oxford Pa
19 (a) Huntington Williams, M.D. Registrar
(Signature of registrar) MAY 14 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 May 1947, at 11 00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11 May 1947 to 21 May 1947, and that I last saw him alive on 21 May 1947.

Immediate cause of death INTESTINAL OBSTRUCTION — Duration 11 DAYS

Due to FETAL DEFORMITY, CONGENITAL ATRESIA DUODENUM. — 11 DAYS

Due to

Other Conditions DILITATION, RT AURICLE AND VENTRICLE

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Postmortem Autopsy performed of autopsy: 5-21-47 Dr. Ullender

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Vernon C. Kelly M. D.
Address Woman's Hospital Date signed 5/21/47

X

G51945 G51915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 317 N. Mount St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 317 N. Mount St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Rogers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Frank Rogers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 28, 1904

8. AGE: Years 43 | Months 2 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Samuel Rainey
13. Birthplace Kent Co, Md

MOTHER
14. Maiden Name Nester Scott
15. Birthplace Kent Co Md

16 (a) Informant Frank Rogers
(b) Address 317 N Mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 22, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St
(c) (Date) 1947 by registrant Huntington Williams MD

MAY 22 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1947, at 12 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 15 1945, to May 19 1947, and that I last saw her alive on May 13 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	5 mo
Due to Hypertension	
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Douglas Sheppard M. D.
Address 604 N Fulton Ave Date signed 5/22/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

651946

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 651946

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.O.A
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 16 N. Bond St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Mae James

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1910

8. AGE: Years	Months	Days	If less than one day
37			hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Packing House Work

11. Industry or business

FATHER
12. Name Loyd James
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Viola Lee
15. Birthplace Baltimore Md

16 (a) Informant Viola James
(b) Address 16 N. Bond St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 22-1947 (month) (day) (year)

(c) Cemetery or crematory Mt Calvery Cem
Location Brooklyn Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 4 5 1947 Washington Ave Curtis Bay, Md

19 (a) MAY 22 1947 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/18 1947, at 3:50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. A. Salvia Jr. M.D.
Medical Examiner.
Date signed 5/18/47

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

051917

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 051917

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1529- E. North Avenue
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES E. OWENS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.) August 11, 1916

8. AGE: Years	Months	Days	If less than one day
30	9	11	hr. min.

9. Birthplace R. D. Salisbury Md.
(Town, county, and state)

10. Usual Occupation Truck Driver

11. Industry or business U.S. Postal Truck

FATHER 12. Name Willie Owens.

13. Birthplace Maryland.

MOTHER 14. Maiden Name Bertha A. Adkins

15. Birthplace Maryland

16 (a) Informant Willie Owens

(b) Address Route 2 Parsonsburg, Md.

17 (a) Burial (b) Date thereof 5-26-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Wicomico Memorial Cemetery

Location Salisbury, Md.

18 (a) Funeral director Holloway & Co.

(b) Address Salisbury, Md.

19 (a) MAY 23 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22, 1947 at 6.35 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Hemorrhage due to Rupture of Liver.

Due to

Other Conditions Fracture of Rt Femur, Fracture of Nose
(Include pregnancy within 3 months of death)

22. If an external cause was ~~primary~~ ☐ or contributing ☐ cause of death, fill in the following: 10/1

(a) Date of injury 5-22-47 at about 6 a. M.

(b) Where did injury occur? Fallsway & Chase St.

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? Yes.

(d) Means of injury Driver truck- struck by auto.

23. Signature Louis H. Kruger M.D.
Medical Examiner

Date signed 5-22-47

VS 151

G51918

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131 B

G51918 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 25-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2606 Pugett St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Albert M Ware

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Fannie Ware

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 26, 1898

8. AGE: Years	Months	Days	If less than one day
48	7	24	hr. min.

9. Birthplace Mt. Winans, Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Richard F. Ware
13. Birthplace Va.

MOTHER
14. Maiden Name Mary R. Henson
15. Birthplace Anne Arundel County

16 (a) Informant Emma Halley
(b) Address 1623 Laurens St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 24, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Arlington Ave

19 MAY 22 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 1947, at 1 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Edema
Contributory Disease Acute Dilatation of Heart
Due to
Other Conditions Chronic Glomerulonephritis
Edema of Brain
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Malkus M.D. Medical Examiner.
Date signed 5-20-47

MARTHA CHASE Thomas

G51949

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 148a

Registered No. G51949

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1306 Madison
(c) Hospital or institution: 11-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1306 Madison
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Chase Thomas

3 (b) If veteran, name war X

3 (c) Social Security Account No. X

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Daniel Lockwood

6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) Jan 1901

8. AGE: Years	Months	Days	If less than one day
46	4		hr. min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation Home

11. Industry or business —

FATHER
12. Name Walter Chase
13. Birthplace A.A. Co. Md

MOTHER
14. Maiden Name Mary Galloway
15. Birthplace Ann Arundel Md

16 (a) Informant Peggy Thomas
(b) Address 1018 Appleton St

17 (a) Burial (b) Date thereof 5-23-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Lebanon
Location Lakeland - Md.

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Schroeder St.

19 (a) Date received MAY 22 1947 (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/20/47 19 8:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/14/47 19 to 5/20/47, and that I last saw h alive on 5/19/47 19

Immediate cause of death	Duration
a Coronary Thrombosis	6 hrs
b Due to	
c Due to	
Other Conditions Terminal Pneumonia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 5/20/47

VS 150

X

C51950

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V186a

Registered No. C51950

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. ~~1044 E. Hoffman~~ 1044 E. Hoffman (Usual street location) Ave.
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Monte Gibson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years 43 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof May 23 1947 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Mt. Calvary Cem
Location

18 (a) Funeral director Adolphus Halsted
(b) Address 918 Druid Hill Ave.

19 (a) (b) Huntington Williams, M.D. Registrar

MAY 22 1947

VS 197

MEDICAL CERTIFICATION

03

20. DATE OF DEATH 5/18 1947, at 7A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH miliary tuberculosis

Due to

Other Conditions Fracture left femur

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☒ cause of death, fill in the following:
(a) Date of injury 5/14/47 at acc. 10/3 M.
(b) Where did injury occur? City Jail
(c) Did injury occur at home, on farm, industrial place, in public place? Jail While at work? No
(d) Means of injury Dropped from a bridge

23. Signature Carl H. Reyer M.D.
Medical Examiner.
Date signed 5-19-47

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH - 132

Registered No. G51951

G51951

CWC-110781

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 16 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1006 W. Lanvale Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Logan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife: Pauline

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 12-1914

8. AGE: Years 33 | Months 3 | Days 9 | If less than one day hr. min.

9. Birthplace South Carolina
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Logan
13. Birthplace ?

MOTHER
14. Maiden Name Jane Venus
15. Birthplace ?

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof May 24 1947 (month) (day) (year)

(c) Cemetery or crematory Mt Carey

Location

18 (a) Funeral director [illegible]

(b) Address [illegible]

19 (Date rec'd by registrar) MAY 22 1947 [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 1947, at 12 Noon

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 1947, to May 21 1947, and that I last saw him alive on May 21 1947.

Immediate cause of death: Pulmonary Tuberculosis — Duration 8 Mos. (?)

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Refused

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Hunt M. D.

Address Balt. City Hosp. Date signed 5-22-47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the cause of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51952

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G51952 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital. 11-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 923 Linden Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM H HARRIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Harristown Catonsville Md
(Town, county, and state)

10. Usual Occupation Butler

11. Industry or business

FATHER 12. Name James Harris

13. Birthplace

MOTHER 14. Maiden Name Cromelia Edwards

15. Birthplace

16 (a) Informant Howard Harris

(b) Address Harristown Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-25-47 (month) (day) (year)

(c) Cemetery or crematory Western Star Cemet

Location

18 (a) Funeral director A. Halsted

(b) Address 918 Druid Hill Ave

19 MAY 22 1947 (Date registered by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21, 1947, at 9.05 M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Earl L Royer M.D.
Medical Examiner.

Date signed 5-22-47

VS 191

G51953

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

G51953 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) One
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 835 Leadenhall St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Hodgins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1917

8. AGE: Years	Months	Days	If less than one day
30			hr. min.

9. Birthplace Suffolk Va (Town, county, and state)
10. Usual Occupation Cook
11. Industry or business Hotel

FATHER
12. Name James Hudgins
13. Birthplace Va

MOTHER
14. Maiden Name Anna Haney
15. Birthplace Va

16 (a) Informant Paul Haney
(b) Address 835 Leadenhall St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 5/23/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn St
Location Balto City

18 (a) Funeral director Daniel J Brown Sr
(b) Address 1054 W Montgomery St

19 MAY 22 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1947, at 3:50 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Stab wound of chest involving heart & lung.
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-19-47 at 3:20 P M.
(b) Where did injury occur? Emerson Hotel
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial Place While at work? yes
(d) Means of injury Sharp Instrument

23. Signature Howard J. Mueller M.D. Medical Examiner.
Date signed 5-20-47

VS 191

G51954 BHF 77583

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

184

G51954 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: President Hosp. 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr. 40 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Lafayette
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 616 W. [illegible] Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eugene Butler Jr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7 1943

8. AGE: Years 3 | Months 11 | Days 17 | If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Eugene Butler Sr
13. Birthplace S.C.

MOTHER
14. Maiden Name Bertinnie Parker
15. Birthplace S.C.

16 (a) Informant Isaiah L. Brown Son
(b) Address 1084 Montgomery St

17 (a) Burial (b) Date thereof May 22 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Mem Gardens
Location [illegible] Balto Co

18 (a) Funeral director Isaiah L. Brown Son
(b) Address 1084 Montgomery St

19 (a) MAY 22 1947 (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1947, at 4 P M

21. I certify that I took charge of the remains described above, held an Autopsy & Inq. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet wound of brain

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 14 hr
(a) Date of injury 5-19-47 at 2:00 P M.
(b) Where did injury occur? 1402 Argyle Ave (outside)
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? no
(d) Means of injury Firearms

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 5-20-47

US 151

G51955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G51955

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St.
(c) Hospital or institution: Lillie Lindsay Tu Con
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henrietta Ballard

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	W.

6 (b) Name of husband or wife William Ballard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 14, 1862

8. AGE: Years	Months	Days	If less than one day
84	7	7	hr. min.

9. Birthplace Prince George Co. Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Samuel Green
13. Birthplace

MOTHER 14. Maiden Name Henrietta Bean
15. Birthplace

16 (a) Informant Lillie Lindsay Tu Con
(b) Address 1200 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 23, 1947 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Ruth Wiedefeld
(b) Address 900 E. Biddle St

MAY 22 1947 (Date received by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 1947, at 11:30AM

21. I certify that death occurred on the date above stated; that I attended deceased from Mch-10 1947, to May 21 1947, and that I last saw her alive on May 21 1947.

Immediate cause of death	Duration
Edema Lungs	2 days.
Due to Chronic Myocarditis	5 yrs
Due to	
Other Conditions Arterio Sclerosis	5 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E. Northar Date signed May 22-47

VS 150

G51956

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G51956

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 727 Deepdene Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 727 Deepdene Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA MOORE LEWIS

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife M. Preston Lewis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 20, 1873

8. AGE: Years	Months	Days	If less than one day
74	3	2	hr. min.

9. Birthplace Balto. Co., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Jacob Shunk
13. Birthplace Balto. Co., Md.

MOTHER
14. Maiden Name Virginia Wells
15. Birthplace Balto., Md.

16 (a) Informant Miss Emily F. Lewis
(b) Address 727 Deepdene Rd.

17 (a) Burail (Burial, cremation, or removal) (b) Date thereof 5/24/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAY 22 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22, 1947, at 1:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 24 Apr. 1947 to 22 May 1947 and that I last saw her alive on 22 May 1947.

Immediate cause of death Acute Heart failure — Duration, 22 May '47
Due to Chronic Myocarditis
Due to Arteriosclerotic C.V. Disease
Other Conditions Arthritis deformans Chronic
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph E. Muse Jr. M. D.
Address 3311 St. Paul St Date signed 5/22/47
Balto. 18 Md

V S 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G51957 ✓ G51957 Registered No. 61

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2807 Brighton ST
(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2807 Brighton ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Emma Olivia Hefner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Henry F

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 27 1894

8. AGE: Years 52 | Months 6 | Days 24 25 | If less than one day hr. min.

9. Birthplace Bear Jersey
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Bent
13. Birthplace Md

MOTHER
14. Maiden Name Rosa Smith
15. Birthplace Md

16 (a) Informant Mrs Henry F Hefner
(b) Address 2807 Brighton ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 24 47 (month) (day) (year)
(c) Cemetery or crematory Mountain View
Location Perry Md

18 (a) Funeral director Henry L Hofstetter
(b) Address 410 [redacted]

19 (a) [illegible] (Date rec'd by registrar) Registrar

MAY 22 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 1947, at 1030 PM

21. I certify that death occurred on the date above stated; that I attended deceased from August 1943 to May 21 1947, and that I last saw h[illegible] alive on May 21 1947.

Immediate cause of death Cerebral Hemorrhage — Duration 2 Hours

Due to Generalized arteriosclerosis with hypertension

Due to Hypertensive heart disease with coronary insufficiency

Other Conditions and congestive failure diabetes

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W Nuichel M. D.

Address 2901 Edmondson Ave Date signed May 24 47

937

G51958

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G51958 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2719 Wilkens Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2719 Wilkens Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kathryn E. Mallalieu

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W.	married

6 (b) Name of husband or wife Carroll F. Mallalieu
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20, 1889

8. AGE: Years	Months	Days	If less than one day
57	10	0	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry J. Wieber
13. Birthplace —

MOTHER
14. Maiden Name Margaret D. Dinges
15. Birthplace —

16 (a) Informant Carroll F. Mallalieu
(b) Address 2719 Wilkens Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 22/47. (month) (day) (year)

(c) Cemetery or crematory Loud Cathedral
Location 4300 Old Frederick Rd

18 (a) Funeral director Henry H. Withe
(b) Address 4101 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

MAY 22 1947

S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/20/47 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1947 to May 19 1947 and that I last saw h[illegible] alive on May 19 1947

Immediate cause of death	Duration
Acute Cardiac Dilatation	One day
Due to Cardio Vascular disease	2 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry Clarence M. D.
Address 2687 Mt. Holly Ave Date signed May 24 47

G51959 ✓ G51959

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 13B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + Saratoga Sts
(c) Hospital or institution: Mercy Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1623 W. Lexington St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Reeder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Married

6 (b) Name of husband or wife Wallace Reeder
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 18, 1901

8. AGE: Years	Months	Days	If less than one day
45	7	2	hr. min.

9. Birthplace Evergreen Alabama (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Abraham Lewis
13. Birthplace Evergreen, Alabama

MOTHER
14. Maiden Name Chanie
15. Birthplace Evergreen Alabama

16 (a) Informant Wallace Reeder
(b) Address 1623 W. Lexington

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 23, 1947 (month) (day) (year)
(c) Cemetery or crematory Mrs Cathedral
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Schroeder St
(c) Huntington Williams, Mgr. (Licensed undertaker) Registrar

MAY 22 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-20 1947, at 3:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-19 1947, to 5-20 1947, and that I last saw h.e.c. alive on 5-20 1947.

Immediate cause of death Respiratory Failure — Duration 6 months

Due to Meningitis — 3 days

Due to Miliary Tuberculosis & Pulmonary Tuberculosis — ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Miliary Tbc + Meningitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William D. Beatty M.D.
Address Mercy Hosp Date signed 5-22-47

VS 150 Duplicate Copy - First Lost by Undertaker

G51960 Hofstetter ✓ G51960

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St
(c) Hospital or institution Bon Secours Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 weeks
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1806 Pinedale Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Josephine Hofstetter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife Anthony M

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch 21 1861

8. AGE: Years	Months	Days	If less than one day
86	2	-	hr. min.

9. Birthplace Ellicott City Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John Veith
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine McAvoy
15. Birthplace Md

16 (a) Informant Mrs Agnes Carney
(b) Address 1806 Pinedale

17 (a) Burial (b) Date thereof 5-23-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Carlin Grad
Location Baltimore Md

18 (a) Funeral director Geo A Tuley
(b) Address Fulton & Fayette

19 (a) May 22 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 196

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 1947 at 4 35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 21 1947 to May 20 1947 and that I last saw h[illegible] alive on May 20 1947.

Immediate cause of death	Duration
cardio-respiratory failure	
Due to general arteriosclerosis	
Due to old age	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E H Krotee Jr M. D.
Address Bon Secours Hosp Date signed 5/23/47

G51961 Woodlawn BC# B78608

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G51961 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 4 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1903 Lanvale Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Baby J Helen Ruffin
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	negro	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-27-47

8. AGE: Years	Months	Days	If less than one day
			4 hr.S. min.

9. Birthplace Balto. md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Earl Ruffin
13. Birthplace Balto. md.

MOTHER
14. Maiden Name Helen Tyree
15. Birthplace Balto. md

16 (a) Informant Helen Ruffin
(b) Address 1903 Lanvale Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School MAY 22 1947
18 (a) Funeral director Commissioner of Health
(b) Address
MAY 23 1947 Huntington Williams, M.D.
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-27- 1947, at 3 P.M
21. I certify that death occurred on the date above stated; that I attended deceased from 11 a.m. 4-27- 1947, to 3 p.m. 4-27 1947, and that I last saw him alive on 4-27- 1947.

Immediate cause of death	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature M. D.
Address Date signed 5-[illegible]-47

X

G51962 City Disposal 160 c 77679

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G51962

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood + Greene St.
(c) Hospital or institution: University Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 504 Myrtle Ave.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Shirdell Venable

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/5/47

8. AGE: Years	Months	Days	If less than one day
		6	hr. min.

9. Birthplace Maryland.
(Town, county, and state)
10. Usual Occupation Infant.
11. Industry or business

FATHER
12. Name Homewood Dawkins
13. Birthplace Virginia

MOTHER
14. Maiden Name Jeanette Johnson
15. Birthplace Maryland

16 (a) Informant Mother
(b) Address 504 Myrtle Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School MAY 16 1947

18 (a) Funeral director City Disposal.
(b) Address Commissioner of Health

MAY 23 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-11 19 47 at 9 34 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-11 19 47 to 5-11 19 47 and that I last saw him alive on 5-11 19 47

Immediate cause of death	Duration
Peritonitis	
Due to Perforation of bowel.	
Due to Meconium impaction	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy: Same.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gerald Martin M. D.
Address Univ Hosp. Date signed 5-12-47

G51963

BALTIMORE CITY HEALTH DEPARTMENT

BC# B-78314 CERTIFICATE OF DEATH 160c

G51963 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4hr
(e) Length of stay in Baltimore (yrs., mos., or days) 4hr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1209 N. Johnson St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby girl Palmer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex ♀ F | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/8/47

8. AGE: Years | Months | Days | If less than one day 7 hr. 20 min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation infant

11. Industry or business

FATHER 12. Name Mead Palmer

13. Birthplace Richmond Co., Va.

MOTHER 14. Maiden Name Eva Wolf

15. Birthplace Phila., Penna.

16 (a) Informant Eva W. Palmer

(b) Address 1209 N. Johnson, Ballto, Md

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School MAY 16 1947

18 (a) Funeral director Commissioner of Health

(b) Address

MAY 23 1947 (Date rec'd by registrar) Huntington Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 1947 at 4:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 8 1947, to May 8 1947, and that I last saw h[illegible] alive on May 8 1947

Immediate cause of death Anoxia — Duration

Due to Anemia

Due to Hemorrhage from placenta

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry P. Hamilton M. D.

Address University Hosp. Date signed 5/9/47

VS 150

G51964

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BC# 284986 159

G51964 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood + Green
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 18 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Cockeysville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Heath

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/16/47

8. AGE: Years	Months	Days	If less than one day
0	0	0	18 hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Infant.
11. Industry or business

FATHER 12. Name Charles Heath
13. Birthplace Maryland

MOTHER 14. Maiden Name Mary ~~Heath~~ Wagner
15. Birthplace Maryland

16 (a) Informant Father
(b) Address Sparks, Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School MAY 21 1947

18 (a) Funeral director Commissioner of Health
(b) Address

MAY 23 1947 (Date rec'd by Registrar) (Huntington Williams M.D.)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-17 1947, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-16 1947 to 5-17 1947 and that I last saw him alive on 5-17 1947

Immediate cause of death	Duration
Prematurity.	
Due to 4½ months gestation -	
Due to Birth wt 1 lb 14 oz.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gerald A. Martin M.D.
Address Univ. Hosp. Date signed 5-17-47

VS 150

X

G51965 BC# B78677 BALTIMORE CITY HEALTH DEPARTMENT G51965
CERTIFICATE OF DEATH 159 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7½ hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 4½ hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore (If outside city or town, name township, village, or district, and give county)
(d) Street No. 365 W. Fayette (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ronald Bobby Bay Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 5/17/47

8. AGE: Years — | Months — | Days — | If less than one day 4 hr. 30 min.

9. Birthplace Balto., Balto., Md. (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Don Williams
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Lorraine Mary Kemp
15. Birthplace Middlesex, Va.

16 (a) Informant Lorraine Williams
(b) Address 659 Pierce St., Balto.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery
Location

18 (a) Funeral director
(b) Address

MAY 23 1947 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/17/47 19 , at 3:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 17 19 47 to May 17 19 47, and that I last saw him alive on May 17 19 47.

Immediate cause of death	Duration
Atelectasis	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry F. Hanf Jr., M.D.
Address University Hospital Date signed 5/21/47

MAY 21 1947 Commissioner of Health

VS 150

G51966

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

b-18528 159

Registered No. G51966

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3205 N. Eutaw St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Reinhardt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-14-47

8. AGE: Years | Months | Days | If less than one day: 2 1/2 hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Sigmund Reinhardt
13. Birthplace Md

MOTHER 14. Maiden Name Gertrude White
15. Birthplace Md.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address Records.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School MAY 16 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) MAY 23 1947 Transcribed from Records

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May - 14 1947 at 3. M

21. I certify that death occurred on the date above stated; that I attended deceased from May - 14 1947 to May - 14 1947 and that I last saw h[illegible] alive on May - 14 1947

Immediate cause of death Asphyxia — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lee Mel Bass M. D.

Address Johns Hopkins Hosp. Date signed 5/14/47

X

G51967

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 51c

Registered No. G51967

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital W

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Greenway Apts.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John C. Siegle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Mary D. Siegle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7th 1883

8. AGE: Years	Months	Days	If less than one day
63	11	15	hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)
10. Usual Occupation: Chief Maintenance Building
11. Industry or business: City of Balto

FATHER
12. Name: John Siegle
13. Birthplace: Germany

MOTHER
14. Maiden Name: Caroline (Unknown)
15. Birthplace: "

16 (a) Informant: Mary D. Siegle
(b) Address: Greenway Apts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/24/47 (month) (day) (year)
(c) Cemetery or crematory: Balto.
Location: " Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 127 St. Paul St.

19 (a) MAY 23 1947 (Date rec'd by registrar) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 22 May 1947, at 7.35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/21 1947 to 22 May 1947, and that I last saw h.e alive on 22 May 1947.

Immediate cause of death	Duration
Asphyxiation	
Suicide	
Due to Uremia & Cachexia	
Due to Metastatic malignant cell carcinoma of right testicle	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Carcinoma of r. testicle
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Stanley M. Gordon M. D.
Address: Sinai Hosp. Date signed 5/22/47

VS 150

X

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G51968

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 432 West 23rd Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 432 West 23rd Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John J. White ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 22, 1882

8. AGE: Years	Months	Days	If less than one day
64	9	0	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Edward White
13. Birthplace Ireland

MOTHER
14. Maiden Name Ann Cady
15. Birthplace Ireland

16 (a) Informant Florence Miller
(b) Address 432 West 23rd Street

17 (a) burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Govans, Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) MAY 23 1947 (Date received by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22, 1947, at 9:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 2 1947 to May 22 1947 and that I last saw alive on May 19 47

Immediate cause of death	Duration
Due to Toxemia and Cardiac	
Due to Arteriosclerosis	4 days
Other Conditions Pyelitis Pneumonia (Include pregnancy within 3 months of death)	4 days

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Florence Miller
Address 438 Maryland Ave Date signed 5-22-47
M. D.

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51969

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G51969

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1302 W. Lexington Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1302 W. Lexington Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lily R. Baker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Nelson G. Baker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 16, 1872

8. AGE: Years	Months	Days	If less than one day
75	3	4	hr. min.

9. Birthplace Baltimore County, Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business —

FATHER
12. Name Wesley Mayes
13. Birthplace Unknown

MOTHER
14. Maiden Name Rebecca Carter
15. Birthplace Unknown

16 (a) Informant Charles E. Baker
(b) Address 3919 Falls Road,

17 (a) burial (b) Date thereof 5/23/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory United Brethren
Location Pikesville Md.

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) [illegible] (b)
MAY 23 1947
[illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 1947, at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to May 20 1947, and that I last saw [illegible] alive on May 20 1947

Immediate cause of death [illegible] Duration 10 yrs 10 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 129 E. Biddle Date signed 5-23-47

G51970

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

B# B60012 ✓9

G51970
Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital 12-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 50 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 7 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2802 Miles Ave. ✓
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Martin Shipp / Shipp

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 9, 1946.

8. AGE: Years	Months	Days	If less than one day
	7	4 5	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation child —
11. Industry or business —

FATHER
12. Name William Hatten Shipp.
13. Birthplace Alliance, Ohio.

MOTHER
14. Maiden Name Margaret Mary Hayes.
15. Birthplace Baltimore, Md.

16 (a) Informant William Shipp.
(b) Address 2802 Miles Ave. City.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location MAY 23 1947

18 (a) Funeral director Commissioner of Health
(b) Address

MAY 23 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/14 1947, at 2 40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/14 1947 to 5/14 1947, and that I last saw h alive on 5/14 1947.

Immediate cause of death	Duration
anoxia	
Due to pneumonia	
Due to pertussis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature P.H. Hauser M. D.
Address Sydenham Hospital Date signed 5/14/47

V S 150

X

G51971 NANCY

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓937

Registered No. G51971

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 717 W Lexington St.
(c) Hospital or institution: 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 5 weeks

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 717 W Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Nancy S. Malcomb

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Late Parran

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15th 1876

8. AGE: Years	Months	Days	If less than one day
71	1	7	hr. min.

9. Birthplace Petersburg W. Va. (Town, county, and state)

10. Usual Occupation House work

11. Industry or business at home

FATHER — 12. Name James W. Wilford

13. Birthplace West Va.

MOTHER — 14. Maiden Name Sarah E. Watson

15. Birthplace West Va.

16 (a) Informant Mrs Jeannette Kaminski

(b) Address 717 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/24/47 (month) (day) (year)

(c) Cemetery or crematory Sacred Heart Cem

Location Gerrard Mill Rd.

18 (a) Funeral director John J. Corcoran & Son

(b) Address 901-03 Wallace St.

19 (a) MAY 23 1947 (b) Huntington, Williams, M.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22nd 1947, at 2.55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 21 1947 to May 22 1947, and that I last saw h[illegible] alive on May 22 1947

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertension Cardio Vascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Andrew Simmons M. D.

Address 2529 Eastern Ave. Date signed

5172 72

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G51972

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1703 N. Washington St
(c) Hospital or institution: 81

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1703 N. Washington St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry Mertens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28th 1863

8. AGE: Years	Months	Days	If less than one day
83 64	10	24	hr. min.

9. Birthplace Md (Town, county and state)

10. Usual Occupation Retired Baker

11. Industry or business

FATHER
12. Name Henry Mertens Sr.
13. Birthplace Germany.

MOTHER
14. Maiden Name Rose Rose
15. Birthplace Germany.

16 (a) Informant Mrs Ella M. Mertens
(b) Address 1703 N. Washington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 26th 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Leo Gyle & Son
(b) Address 1701-03 N. Patterson Park Ave

19 (a) MAY 23 1947 (Date received by Registrar) (b) Lexington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1947, at 3:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1946 to May 22 1947 and that I last saw h[illegible] alive on May 22 1947.

Immediate cause of death	Duration
Coronary Artery Occlusion	2 hrs.
Due to Myocardial Insufficiency Hypertension	10 yrs T 10 yrs T
Due to Arteriosclerosis	10 yrs T
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lewis Silverman M. D.
Address 1101 N. Linden Ave Date signed 5-22-47

T

G51973

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1643

Registered No. G51973

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 656 W. Saratoga St
(If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Albert Stevenson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years	Months	Days	If less than one day
49			....hr. ....min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Mary Brown
(b) Address 656 Saratoga St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-21-47 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem
Location.....

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave

19 (a) MAY 23 1947 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1947, at 12 16 PM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Hemorrhage from incised wound of neck

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-17-47 at about 11 P. M.
(b) Where did injury occur? 656 W. Saratoga St. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury sharp instrument

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 5/17/47

VS 131

G51971

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V167

Registered No. G51971

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 16
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 min.
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 808 N. Stricker Street
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Nathaniel Lee

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: S
6 (b) Name of husband or wife: none
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 30, 1930

8. AGE: Years 16 | Months 11 | Days 22 | If less than one day ..... hr. ..... min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business .....

FATHER
12. Name Sylvester Lee
13. Birthplace Md

MOTHER
14. Maiden Name Josephine Johnson
15. Birthplace Md

16 (a) Informant Josephine Lee
(b) Address 808 N. Stricker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/26/47 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Md

18 (a) Funeral director Wes. H. Kelson
(b) Address 1303 Presstman St

19 Date received by registrar MAY 23 1947 Washington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21, 1947, at 11.30 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Stab wounds of scalp involving brain

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-21-47, at 10.30 p. M.
(b) Where did injury occur? 709 N. Fulton Ave. outside— Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Sharp instrument

23. Signature Earl L Royer M.D.
Medical Examiner.
Date signed 5-22-47

X

C51975

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. C51975

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1502 Rutter St.
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1502 Rutter St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Stewart

3 (b) If veteran, name war: Spanish American
3 (c) Social Security Account No. 213-14-0762

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Married

6 (b) Name of ~~husband~~ or wife Ella Stewart
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
69			hr. min.

9. Birthplace Chestertown, Md.
(Town, county, and state)
10. Usual Occupation Janator
11. Industry or business Nat. Harvester Co.

FATHER
12. Name James Stewart
13. Birthplace Chestertown, Md

MOTHER
14. Maiden Name Eliza Union
15. Birthplace Chestertown, Md

16 (a) Informant Ella Stewart
(b) Address 1502 Rutter St

17 (a) Burial (b) Date thereof May 25 '47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
— Location Brooklyn
18 (a) Funeral director P. Brooks
(b) Address 1463 N. Carey St
19 (a) MAY 23 1947 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1947, at 6.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 23 1947 to May 22 1947 and that I last saw h. in. alive on May 1 1947.

Immediate cause of death	Duration
Myocardial insufficiency	1 day
Due to Myocarditis	1 week
Due to	
Other Conditions Acute bronchitis	2 wks

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas. J. Kelly M. D.
Address 211 W. Monument St Date signed May 23 47

VS 150

G51976

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G51976
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 755 W. Fayette Street
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Nibbon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace (Town, county and state) Unknown

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace Unknown

MOTHER
14. Maiden Name
15. Birthplace Unknown

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory University Medical School MAY 22 1947
Location Commissioner of Health

18 (a) Funeral director
(b) Address

MAY 23 1947 (Date rec'd by registrar) (Signature) Huntington Williams, M.D.

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/11/47 19 , at 5:30 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis, Medical Examiner, M.D.
Date signed 5/14/47

G51977

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/31a

G51977
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1505 N. Stricker St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1505 N. Stricker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CORA LANE

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Unknown
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School MAY 22 1947

18 (a) Funeral director Commissioner of Health
(b) Address

(c) MAY 23 1947 (Date received by registrar) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION 30

20. DATE OF DEATH May 8, 1947, at 12 p M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to 4er death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardio-vascular-renal disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 5-9-47

G51978

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G51978

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette and Calhoun
(c) Hospital or institution:
Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7614 Hackett Ave. #24
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Roy Wallace

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Lillie Mae Wallace
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 7, 1903

8. AGE: Years	Months	Days	If less than one day
44	1	13	hr. min.

9. Birthplace St. Louis, Mo.
(Town, county, and state)
10. Usual Occupation ?
11. Industry or business

FATHER
12. Name James Wallace
13. Birthplace Missouri

MOTHER
14. Maiden Name Rosie Tucker
15. Birthplace Missouri

16 (a) Informant Lillie Mae Wallace
(b) Address 7614 Hackett Ave. #24

17 (a) Cremation (b) Date thereof 5-23-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Dodge Park
Location Frederick, Md.
18 (a) Funeral director John F. Donnelly
(b) Address 44 Eastern Ave.

MAY 23 1947
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 1947, at 3:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 20 1947 to May 20 1947, and that I last saw him alive on May 20 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	19 hrs.
Post diagnosis deferred pending path report	
Due to Cause unknown	
Due to	
Other Conditions Generalized Sclerosis - Arteria.	9 mos.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mabel H. Ramsdell M. D.
Address Frank. Sq. Hosp. Date signed 5-20-47

VS 150

G51979

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

56 B

Registered No. G51979

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2722 St. Paul St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2722 St. Paul St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME M. GERTRUDE WARDIN

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife John Owens Wardin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 21, 1865

8. AGE: Years	Months	Days	If less than one day
81	5	0	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired Supt. Nurses Home
11. Industry or business State Sanatorium

FATHER
12. Name John H. H. Taylor
13. Birthplace Annapolis, Md.

MOTHER
14. Maiden Name Martha Ann Green
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Florence M. Taylor, sister
(b) Address 2722 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/24/47 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAY 23 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21, 1947, at 10:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to May 21 1947 and that I last saw her alive on May 19 1947.

Immediate cause of death chronic myocardial failure
myocardial failure - Duration May 19/47
Cardio - Vascular - Renal - Disease
Due to arterio - sclerosis -
Due to
Other Conditions Abdominal Tumor
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —
23. Signature Louis H. Tremblay M. D.
Address 222 No. Kenwood Ave. Date signed May 24/47

V S 150

131a

G51980 CM

French 110737

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G51980

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 15 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 3Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1800 Walbrook Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME French Susie

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 3-1864

8. AGE: Years	Months	Days	If less than one day
83	4	18	hr. min.

9. Birthplace MD (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Horace Knight
13. Birthplace MD

MOTHER
14. Maiden Name Eleanor Getty
15. Birthplace N.C.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 24 1947 (month) (day) (year)
(c) Cemetery or crematory St. Mary's Cem.
Location Baltimore Md

18 (a) Funeral director Maguire & Dyer
(b) Address 1600 N. North Ave

19 (Date rec'd by registrar) MAY 23 1947 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 1947, at 2.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 18 1947 to May 21 1947, and that I last saw h or alive on May 21 1947.

Immediate cause of death Arteriosclerotic Ht. Disease & Pulmonary Edema

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H.H. Faulee M. D.
Address Balto City Hosp Date signed 5-21-47

X

G51981

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G51981 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2027 Hubbard St ~~Spurlock St~~
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2027 Hubbard St. Herbert. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELLA JANE PAULSEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Hans Poulsen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) aug. 11-1897

8. AGE: Years	Months	Days	If less than one day
49	9	11	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Home duties

11. Industry or business

FATHER 12. Name John Kaude

13. Birthplace Woodlawn Md.

MOTHER 14. Maiden Name Ella Jane Temple

15. Birthplace Woodlawn.

16 (a) Informant Harry Eisel

(b) Address 2027 Herbert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 23-1947 (month) (day) (year)

(c) Cemetery or crematory Baltor National Park

Location Balto. Md.

18 (a) Funeral director Jeannie Cook Dyer

(b) Address 4000 W. North Ave.

19 MAY 23 1947 (Date rec'd by registrar) Huntington Williams, M.D. (Registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20, 1947, at 6.35 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Earl L. Royer M.D.
Medical Examiner.

Date signed

G51982

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G51982 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 673 Lexington Street
(c) Hospital or institution: 4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 673 West Lexington Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLARENCE L. HUBBARD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Beulah D. Hubbard
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Jan 8, 1891

8. AGE: Years	Months	Days	If less than one day
56	4	13	hr. min.

9. Birthplace Marrinnetta, Wisc.
(Town, county, and state)

10. Usual Occupation Auto-Salesman
11. Industry or business Buick Agency

FATHER
12. Name Leonard Hubbard
13. Birthplace Wisconsin

MOTHER
14. Maiden Name Margaret Ross
15. Birthplace Wisconsin

16 (a) Informant Mrs. Beulah D. Hubbard (wife)
(b) Address 2607 Dulaney Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 23 May 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director F. B. Wippert & Son
(b) Address 1300 Eutaw Place -- 17

19 (a) MAY 23 1947 Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21st 19 47, at 5:30 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardiovascular disease disease

Due to

Other Conditions Pernicious Anemia
(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G. Helfrich, M.D.
Medical Examiner.
Date signed 5-22-47 Co. Howard J. Weedon, M.D.

G51983

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

G51983 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days.
(e) Length of stay in Baltimore (yrs., mos., or days) Hosp

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 13
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2329 Division St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Bright

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-13-89

8. AGE: Years 58 | Months 1 | Days 9 | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Plumber

11. Industry or business

FATHER 12. Name John Bright

13. Birthplace Va.

MOTHER 14. Maiden Name Fannie Smith

15. Birthplace Va.

16 (a) Informant JOHNS HOPKINS HOSPITAL Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 26 1947 (month) (day) (year)

(c) Cemetery or crematory

Location Gloucester, Va.

18 (a) Funeral director Mrs. Geo. W. Holland

(b) Address 1631 Druid Hill Ave.

19 (a) (Date received by registrar) (b) Washington Nitkamp, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1947, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 5 1947, to May 22 1947, and that I last saw him alive on May 22 1947

Immediate cause of death	Duration
Hepatic Insufficiency	6 Mos
Due to Prolonged Jaundice	4 Mos
Due to Carcinoma of Pancreas	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 5/12, 5/16, 5/19, 5/21/1947

Major findings of operation: Ca of pancreas

of autopsy: Biliary Cirrhosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard C. Clay M. D.

Address Johns Hopkins Hosp. Date signed 5/23/47

X

G51981

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G51981

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 416 Mosher St
(c) Hospital or institution: 14

(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 416 Mosher
(If rural give location)
(e) If foreign born, how long in U. S. A.? ..... years

3 (a) FULL NAME Jennette Hall

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widow

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 24, 1858

8. AGE: Years	Months	Days	If less than one day
89	6	27	..... hr. ..... min.

9. Birthplace Balto, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Walter Johnson
13. Birthplace Balto. Maryland

MOTHER
14. Maiden Name ? Dawer
15. Birthplace Balto, Md.

16 (a) Informant Miss Edna Brown
(b) Address 416 Mosher St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 24, 1937 (month) (day) (year)
(c) Cemetery or crematory Arlington Memorial Park
Location .....

18 (a) Funeral director Mrs. Geo. W. Holland
(b) Address 1631 Druid Hill Ave.

(a) Date received by Registrar MAY 25 1937 (b) Registrar's signature Augustus Jones, M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 1937, at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from October 1945, to May 21 1937, and that I last saw h.. alive on 5-21 1937.

Immediate cause of death: Arteriosclerotic heart disease — Duration 6 years
Due to: .....
Due to: Bronchitis etc
Other Conditions: .....
(Include pregnancy within 3 months of death)
Major findings:
Of operations: .....
Of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence .....
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature H. P. Stephens
Address 825 N. Fremont Ave. Date signed M 5 D 23 '37

G51985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G51985 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1409 W. Lafayette Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1409 W. Lafayette Ave (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Rebecca Anne Gibson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Jacob J. Gibson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 25 1876

8. AGE: Years 71 Months 3 Days 28 If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation domestic

11. Industry or business None

FATHER 12. Name Thomas Lomax

13. Birthplace Annapolis, Md

MOTHER 14. Maiden Name Sarah A. Meades

15. Birthplace Baltimore, Md.

16 (a) Informant Mrs Estelle Barnes

(b) Address 1409 W. Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 25 1947 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial Park

Location

18 (a) Funeral director Mrs. Geo. H. Holland

(b) Address 1631 Druid Hill Ave.

MAY 29 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1947 at 6a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-8- 1946 to 5-22- 1947 and that I last saw her alive on 5-21- 1947

Immediate cause of death Cardio vascular renal disease — Duration 14 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John E. J. Camper M. D.

Address 639 N. Carey Date signed 5-23-47

X

G51986

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G51986

Registered No.

MARGIN RESERVED FOR BINDING.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County York
(c) City or town Bridgeton
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abram Pyle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Hannah Pyle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 6 1858

8. AGE: Years	Months	Days	If less than one day
89	3	17	hr. min.

9. Birthplace York Co Pa
(Town, county, and state)

10. Usual Occupation Retired Farmer

11. Industry or business

FATHER
12. Name Daniel Pyle
13. Birthplace York Co Pa

MOTHER
14. Maiden Name Rhoda A Forbes
15. Birthplace York Co Pa

16 (a) Informant Jno Wm Pyle
(b) Address York Pa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 26th 47
(month) (day) (year)

(c) Cemetery or crematory Prospect
Location Gatchelville Fairfield Pa

18 (a) Funeral director H Worley Hess
(b) Address Fairfield Pa

19 (Date received by registrar) MAY 23 1947 Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-23- 1947; at 4:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to Generalized Arteriosclerosis

Other Conditions Multiple fractures of ribs + sternum; cirrhosis of liver.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-15-47 at 10 A.M.
(b) Where did injury occur? Bridgeton, Pa.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Struck by auto.

23. Signature Earl H Royer M.D.
Medical Examiner.

Date signed 5/23/47

G51987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 307

Registered No. G51987

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 635 N. Johns Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 635 N. Johns Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Nellie Carle Fisher

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: John L. Fisher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22-1864

8. AGE: Years 83 | Months 3 | Days — | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Thomas E. Carle
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary E. —
15. Birthplace Maryland

16 (a) Informant John L. Fisher
(b) Address 635 N. Johns Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 24-1947 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) MAY 23 1947 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1947, at 9 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1942 to May 22 1947 and that I last saw her alive on May 17 1947.

Immediate cause of death	Duration
Hypertensive Cardiovascular disease	5 yrs+
Due to Arteriosclerosis	5 yrs+
Due to	
Other Conditions Aneurism of abdominal aorta	5 yrs+

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Francis W. Gluck M. D.
Address 715 Park Ave Date signed 5/22/47

V S 150

937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51988

109722-AB

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G51988

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 39days
(e) Length of stay in Baltimore (yrs., mos., or days) 25yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 646 W. Franklin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Richards

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race Col.

6 (a) Single, married, widowed, or divorced. Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25- 1901

8. AGE: Years 46 | Months 1 | Days 22 | If less than one day hr. min.

9. Birthplace Ga.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jessie
13. Birthplace Ga.

MOTHER
14. Maiden Name Rebecca
15. Birthplace Ga.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 23-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location Brooklyn Md

18 (a) Funeral director Elmer O. Wilson
(b) Address 1110 Bonney ave

19 MAY 23 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1947, at 5.30AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-8- 1947, to 5-17 1947, and that I last saw h. alive on 5-17 1947.

Immediate cause of death Carcinoma of S.C. System — Duration 10 mon.t

Due to — Duration

Due to — Duration

Other Conditions Pulmonary Tuberculosis — Duration 3 mon.t
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Not Done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Hunt M. D.
Address Balt. City Hosp. Date signed 5-22-47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G51989

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 148a

Registered No. G51989

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1214 E. Preston St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1214 E Preston St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY N. WILLIAMS

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widow

6 (b) Name of husband or wife Spouse
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-21-1888

8. AGE: Years	Months	Days	If less than one day
59	2	-	hr. min.

9. Birthplace Sussex Co. Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Taylor
13. Birthplace VA.

MOTHER
14. Maiden Name Susie ?
15. Birthplace VA

16 (a) Informant Jamie Williams
(b) Address 1214 E Preston St

17 (a) Removal (b) Date thereof 5-24-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Little Mt. Cem.
Location Sussex County, Va.
18 (a) Funeral director Dwight E. Oliver
(b) Address 1360 N. Carrollton

19 MAY 23 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-21 1947, at 8:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-27 1947 to 5-21 1947 and that I last saw h alive on 5-20 1947.

Immediate cause of death Cerebral Hemorrhage

	Duration
Due to	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. K. Adams M.D.
Address 1222 N. Carrollton Date signed 5-24-47

VS 150

G51336 Dr. Swiss 6232 Belair Road

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G51990

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6115 Fairdel Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6115 Fairdel Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Jirsa

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Joseph Jirsa

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1867

8. AGE: Years	Months	Days	If less than one day
80	-	-	hr. min.

9. Birthplace Czechoslavokis
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr. Charles Jirsa
(b) Address 6115 Fairdel Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/24/47 (month) (day) (year)
(c) Cemetery or crematory Darlington Cem.
Location Darlington, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (Date rec'd by registrar) MAY 23 1947 (Signature) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21st, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 30, 1946, to May 21 1947, and that I last saw her alive on May 19 1947.

Immediate cause of death Arteriosclerotic heart disease — Duration 20 yrs ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Adam Gluvis M. D.
Address 6232 Belair Road Date signed May 23, 1947

V S 150

Dr. Harbold

G51991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered No. G51991

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2914 Markley Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2914 Markley Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Myrtle Penthena Nix

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Elmer M. Nix
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15-1888

8. AGE: Years	Months	Days	If less than one day
58	8	6	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Ulysses Harrison
13. Birthplace Ohio

MOTHER
14. Maiden Name Emma Burke
15. Birthplace ohio

16 (a) Informant Mrs. Hazel Floyd
(b) Address 2914 Markley Ave

17 (a) Burial (b) Date thereof 5/24/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Baltimore' Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 MAY 23 1947 (b) Huntington-Williams Mort
(Date Rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21, 1947, at 8:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 12 1944 to May 21 1947, and that I last saw h. alive on May 20 1947.

Immediate cause of death	Duration
Carcinoma of Bladder	2 years
Due to	
Due to	
Other Conditions Chronic Myocarditis, Anasarca	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. V. Harbold M. D.
Address 4206 Harford Road Date signed 5/25/47

V S 150

G51992 Anastasia

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 170c

Registered No. G51992

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo. 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Pikesville (If outside city or town limits, write RURAL and give town)
(d) Street No. #1 W. Woodholme Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anastasia Hooker

3 (b) If veteran, name war -

3 (c) Social Security Account No. 212-26-5915

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17, 1929

8. AGE: Years 17 | Months 11 | Days 6 | If less than one day ____hr. ____min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Wrapper

11. Industry or business The Hub

FATHER
12. Name Joseph G. Hooker
13. Birthplace Woodlawn

MOTHER
14. Maiden Name Margaret Kehoe
15. Birthplace Baltimore

16 (a) Informant Mrs. Mildred Nichols
(b) Address Woodholme Ave., Pikesville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/26/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 MAY 23 1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23rd 1947 at 1 35 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Ruptured Spleen
Fracture Pelvis
Due to Compound fracture - Tibia & fibula
Other Conditions Laceration of bowel & bruises
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5/22/47 at 10:50 P. M.
(b) Where did injury occur? Pinetuckers + Woodholme Road
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Struck by auto while alighting from bus

23. Signature Howard J. Mueller M.D. Medical Examiner.
Date signed 5-23-47

VS 151

X

ANNIE C. BESTE

G51993

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G51993

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 North Patterson Park
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 N. Patterson Park (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE BESTE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife AUGUST

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 15, 1865

8. AGE: Years 81 | Months 8 | Days 7 | If less than one day ... hr. ... min.

9. Birthplace WASHINGTON D.C. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Gordon
13. Birthplace Not Known

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Frederick F. Beste

(b) Address 3010 Orlando Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/24/47 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location 7725 Eastern Ave

18 (a) Funeral director Blanche F. Hoffman

(b) Address 1639 Broadway

19 (Date rec'd by registrar) MAY 23 1947 Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/22/47 19... at 1:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ... at ... M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John R. Lewis, M.D. Medical Examiner.

Date signed 5/23/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C51994

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 131 B

Registered No. C51994

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 823 George st.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 823 George st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lula Daniels

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Col

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years 58 | Months | Days | If less than one day hr. min.

9. Birthplace Milagenville, Ga. (Town, county, and state)

10. Usual Occupation Housework.

11. Industry or business

FATHER
12. Name Wright Jordan
13. Birthplace Ga.

MOTHER
14. Maiden Name Mary Jordan
15. Birthplace Ga.

16 (a) Informant Hattie Johnson Allen
(b) Address 1131 E. Franklin

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 27th (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location Baltimore "

18 (a) Funeral director Elwood Wilson
(b) Address 1000

19 (a) (Date received by local registrar) (b)

MAY 23 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 1947 at 6:23 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 16 1947, to May 21 1947. and that I last saw h. alive on May 20 1947.

Immediate cause of death: Pulmonary Edema
Due to: Chronic Hypertension
Due to:

Duration

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 601 N. Carrollton Ave. Signed May 23 1947

G51395

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G51395 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1125 Argyle Ave.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Peter Washington

3 (b) If veteran, name war: WWI
3 (c) Social Security Account No.:

4. Sex: M
5. Color or race: col
6 (a) Single, married, widowed, or divorced: Sep.
6 (b) Name of husband or wife: Henrietta Connor Washington
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1887

8. AGE: Years 59 | Months 5 | Days 25 | If less than one day: hr. min.

9. Birthplace Charlestown, S.C.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name ? Wm. Washington
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (b) Date thereof 5/22/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Fredrick Ave.
18 (a) Funeral director Charles R. Lane
(b) Address 802 Madison Ave
19 MAY 23 1947 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH May 20 1947, at 11:18 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 17 1947 to May 20 1947 and that I last saw him alive on May 20 1947.

Immediate cause of death: acute suppurative nephritis & prostatitis with uremia. Diabetes mellitus — Duration

Disease: terminal bronchiopneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank B. Snell M. D.
Address U.S. Marine Hospital Date signed

Balto 11 Md. × 5-21-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51996 BCH # 79292

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √159

Registered No. G51996

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt 12 (If outside city or town limits, write RURAL and give town)
(d) Street No. 327 Paddington (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Faal

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/20/47

8. AGE: Years	Months	Days	If less than one day
0	0	2	hr. min.

9. Birthplace Balt. Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER 12. Name Alfred Coffman Faal
13. Birthplace Balt Md

MOTHER 14. Maiden Name Julia Mae Burns
15. Birthplace Balt Md

16 (a) Informant Julia B Faal
(b) Address 327 Paddington Balto 12

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/24/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3701 Frederick Rd.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1701 Eutaw Place

MAY 23 1947 (Date rec'd by Registrar) (b) Thurlington Williams, M.D. Address

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/22 1947, at 9:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from ~~born~~ 5/20 1947, to 5/22 1947, and that I last saw her alive on 5/22 1947.

Immediate cause of death Prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Ogburn M. D.
Address Date signed 5/22

X

V8 150

G51997

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (92)

Registered No. G51997

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3015 Gwynn's Falls Parkway
(c) Hospital or institution:
none
15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3015 Gwynn's Falls Parkway
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Amanda Ella Cromwell

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 30, 1864

8. AGE: Years	Months	Days	If less than one day
82	6	21	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name John G. Cromwell
13. Birthplace Anne Arundel Co., Md.

MOTHER
14. Maiden Name Amanda E. Harman
15. Birthplace Anne Arundel Co., Md.

16 (a) Informant Lula E. Tydings
(b) Address 3015 Gwynns Falls Parkway

17 (a) Burial (b) Date thereof 5/24/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery Cedar Hill
Location Annapolis Blvd.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) MAY 23 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 8 1947 to 5/21/47 19
and that I last saw h alive on 5/21/47 19

Immediate cause of death — Duration
Cardiac Colitis
Due to Senile
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Helen F. Lowe
Address 4012 Edmondson Ave. Date signed 5/27/47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C51998

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C51998

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Greenmount
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Maryland
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) Md
(d) Street No. 2728 Maryland Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edgar T Read

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Daisy A Read
6 (c) If dlive, give age years

7. Birth date of deceased (mo., day, yr.) June 17, 1874

8. AGE: Years	Months	Days	If less than one day
72	11	4 5	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired Methodist minister
11. Industry or business "

FATHER
12. Name Rev. John Edgar Read
13. Birthplace Maryland

MOTHER
14. Maiden Name Catherine A Thomas
15. Birthplace Maryland

16 (a) Informant Mrs Read
(b) Address 2725 Maryland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/26/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John D. Mitchell & Sons Inc.
(b) Address 1900 Eutaw Place

19 MAY 23 1947 (Date rec'd by registrar) (b) Thurston Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1947, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 20 1947 to May 22 1947, and that I last saw h[illegible] alive on May 22 19 47

Immediate cause of death: Shock — Duration

Due to: Myocardial infarction

Due to: Coronary Thrombosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Kimball M. D.
Address Union Mem. Hosp. Date signed 5-22-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51999

CWK-83817

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G51999

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3- 8- 6-

(e) Length of stay in Baltimore (yrs., mos., or days) 86- 6- 17-

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 419 E. Lanvale Street (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mary Anne McIntyre

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Harry McIntyre (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 4-1860

8. AGE: Years	Months	Days	If less than one day
86	6 (6)	17	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name John Ellwood

13. Birthplace Ireland

MOTHER

14. Maiden Name Mary Gardner

15. Birthplace Ireland

16 (a) Informant Records-Balto. City Hospitals

(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 24, 1947 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore

18 (a) Funeral director Rita Weisfeld

(b) Address 900 East Biddle St.

19 MAY 23, 1947 (b) Huntington Williams M.D.

MEDICAL CERTIFICATION A

20. DATE OF DEATH May 21 1947, at 2:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 15 1946 to May 21 1947, and that I last saw her alive on May 21 1947

Immediate cause of death

Cong. Failure

Arteriosclerotic CVD

Due to

Due to Cholecystitis & Cholelithiasis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy As above

Duration
yrs.
at least yrs.

PHYSICIAN

Underline the cause to which death should be changed statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Edmund Beadnam M. D.

Address Baltimore City Hosp. Date signed May 24 1947

VS 150

G52000

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓927

G52000 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1014 E.Chase Street.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1014 E. Chase Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN KROENER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	widowed

6 (b) Name of husband or wife Susan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15,1877

8. AGE: Years	Months	Days	If less than one day
70	2	8	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Cigar Maker

11. Industry or business Self

FATHER
12. Name Kroener
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Kate
15. Birthplace Baltimore, Maryland

16 (a) Informant Mr. Charles R. Kroener
(b) Address 1014 E. Chase Street

17 (a) burial (b) Date thereof 5/26/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

MAY 28 1947 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23, 1947, at 8.15 a M

21. I certify that I took charge of the remains described above, held an insp.&inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Wallace M.D.
Medical Examiner.
Date signed 5-23-47

G52001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 43a

Registered No. G52001

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGIN RESERVED FOR BINDING

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Essex (If outside city or town limits, write RURAL and give town)
(d) Street No. Eastern & Riverside Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Leslie Ray Swiger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife Goldie Phillips

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-23-1902

8. AGE: Years	Months	Days	If less than one day
44	11	8	hr. min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual Occupation Steel Worker

11. Industry or business Steel

FATHER
12. Name Colommbus Swiger
13. Birthplace W. Va.

MOTHER
14. Maiden Name Anna McCormic
15. Birthplace W. Va.

16 (a) Informant Goldie Phillips-wife
(b) Address Eastern & Riverside Aves.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-4-1947 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial
Location Harford Rd.

18 (a) Funeral director Lilly & Zeiler, Inc.
(b) Address 403 S. Wolfe St.

19 (a) June 3 1947 (b) Huntington, W. Va.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 1947, at 8 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subarachnoid Hemorrhage (Aneurism)

Due to

Other Conditions Fract. simple left temporal bone.

(Include pregnancy within 3 months of death)

Was not cause of Death

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-9-47 at 1:35 A. M.
(b) Where did injury occur? North Point Rd & Moffet Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Struck by Left R. fen. auto.

23. Signature Emil Lang M.D. (Medical Examiner)

Date signed June 2, 1947

VS 181

G52002

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G52002

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Balto. Gen. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4410 Wentworth Road
(If rural give location)
(e) Citizen of foreign country? Nat (Yes or No)
If yes, name country

3 (a) FULL NAME Florence E. Wooters

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Joseph A. Wooters

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 12, 1871 1870

8. AGE: Years	Months	Days	If less than one day
76	7	9	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation none Housewife

11. Industry or business

FATHER
12. Name Jacob Meyers
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary E. Wagner
15. Birthplace Baltimore Md

16 (a) Informant Mrs. L. Brent Frey Daughter-in-Law
(b) Address 4410 Wentworth Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 24, 1947 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director Miles Lamoreaux
Address 4810 Liberty Heights Ave.

MAY 24 1947

19 (a) (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 1947, at 5:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 20 1947, to May 21 1947, and that I last saw h[er] alive on May 21 1947

Immediate cause of death: Myocardial Failure — Duration 2 weeks.

Due to Arteriosclerosis — Duration unknown.

Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold Hillman M. D.
Address South Balto Gen. Hosp. Date signed May 24, 1947

VS 150

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C52003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a

Registered No. C52003

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6028 Old Harford Rd
(c) Hospital or institution: Beech Hill Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3029 Acton st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary F. Airey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single, married~~, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Thomas Joseph Airey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28th 1864

8. AGE: Years 82 | Months 9 | Days 23 | If less than one day hr. min.

9. Birthplace St. Mary's Co. Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER
12. Name Thomas Bell
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Wise
15. Birthplace Md.

16 (a) Informant Mrs Belle Dunbar
(b) Address 5512 Willys Ave

17 (a) Burial (b) Date thereof 5/24/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. Md

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 MAY 24 1947 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21st 1947, at 7.22 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to May 21 1947 and that I last saw her alive on May 20 1947

Immediate cause of death: Carcinoma of cervix & uterus — Duration 11 mos

Due to

Due to

Other Conditions Secondary Anemia, Secondary Asthenia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. F. Harford MD M. D.

Address 4706 Harford Road Signed 5/23/47

C52004 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. C52004

CERTIFICATE OF DEATH 94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2617 E. Monument Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2617 E. Monument Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry Irving Domm

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Married

6 (b) Name of husband or wife Pearl
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) August 27, 1886

8. AGE: Years	Months	Days	If less than one day
60	8	25	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Roofing Contractor
11. Industry or business

FATHER
12. Name Harry Domm
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Sarah Ann Brown
15. Birthplace Baltimore, Maryland

16 (a) Informant Pearl Domm
(b) Address 2617 E. Monument Street

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 5/24/27 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) MAY 24 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22, 1947, at 4:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/19 1935, to May 22 1947, and that I last saw h. alive on May 21 1947

Immediate cause of death Coronary artery disease 10 yrs. — Duration

Due to Arteriosclerosis - generalized — ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis F. Klemer M. D.
Address 2235 E. Monument Date signed 5/23/47

Dr Heffrich
5704 Roland Avenue

C52005

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C52005

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5704 Roland Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5704 Roland Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha Jones

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife John Albert Jones
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2, 1907

8. AGE: Years	Months	Days	If less than one day
39	10	19	hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant John A. Jones
(b) Address 5704 Roland Avenue

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 5/24/47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1213 St. Paul Street

19 (a) MAY 24 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21, 1947, at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from January 1947 to May 1947 and that I last saw her alive on May 20 1947

Immediate cause of death	Duration
Pulmonary tuberculosis	Several months
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Heffrich, M.D.
Address 5706 Roland Ave Date signed May 24, 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52006

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. G52006

1. PLACE OF DEATH:
(a) Baltimore City, Maryland St/ James Apt. #205
(b) Street address 530 N. Charles Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 530 N. Charles Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** ELLA METTA SOPHIA HORSTMEIER

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1865

8. AGE: Years	Months	Days	If less than one day
82	0	9	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation School Teacher - Retired
11. Industry or business Balto. Public Schools

FATHER
12. Name Conrad Horstmeier
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Margaret Haefner
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Laura H. Miller
(b) Address St. James Apts. No. 205

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/24/47 (month) (day) (year)
(c) Cemetery or crematory Trinity Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) MAY 24 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 1947, at 10.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 18 1947, to May 31 1947, and that I last saw h[illegible] alive on May 31 1947.

Immediate cause of death

	Duration
cachexia myocardial insuff.	2 wks.
Urinary carcinomatosis ?	?
Due to carcinoma of uterus	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. C. Sobtlet M.D.
Address 447 N. Kenwood Ave. Date signed 6/2/47 (M. D.)

VS 150

TG52007

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Over 82

Registered No. G52007

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1306 Homestead St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1306 Homestead St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN FREDERICK HAUBERT

3 (b) If veteran, name war: none
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Helena Belz Haubert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 29, (1882) 63

8. AGE: Years (64) 63 | Months 8 | Days 23 | If less than one day hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Greenmount Cem. Co.

FATHER
12. Name John F. Haubert
13. Birthplace Germany

MOTHER
14. Maiden Name (Barbara Schau) Rose
15. Birthplace Germany

16 (a) Informant Mrs. Helena S. (Haul) Haubert
(b) Address 1306 Homestead St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/26/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

MAY 24 1947 (b) Huntington Williams, M.D. Registrar
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22, 1947, at 9:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 21 1944 to May 22 1947 and that I last saw h[illegible] alive on May 21, 1947.

Immediate cause of death: Amyotrophic Lateral Sclerosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel B. Wolf, M.D.
Address 1331 E. North Ave. Date signed 5-24-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered, and the answer written in the proper space. Be sure the cause of death clearly and legibly, correct age is especially important. Physicians, please write the cause of death clearly and legibly.

V S 150

G52008

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G52008 Registered No. 164c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.O.A.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 35 E. 25th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: HARRY GRIFFITHS McCOY

3 (b) If veteran, name war: World War II

3 (c) Social Security Account No. 220-18-5180

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1927

8. AGE: Years 19 | Months 5 | Days 24 | If less than one day hr. min.

9. Birthplace Cumberland, Md.
(Town, county, and state)

10. Usual Occupation Student

11. Industry or business

12. Name Robert R. McCoy

13. Birthplace Columbus, Ohio

14. Maiden Name Florence Inez Griffiths

15. Birthplace Pittsburgh, Pa.

16 (a) Informant Mrs. Florence G. McCoy

(b) Address 35 E. 25th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/26/47 (month) (day) (year)

(c) Cemetery or crematory Western Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) MAY 24 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/22/47 at 6.45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Bullet wound of brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 5/22/47

(b) Where did injury occur? 35 E. 25th St

(c) Did injury occur at home, on farm, industrial place, in public place? Astor Ct. Apts While at work? No

(d) Means of injury Firearms

23. Signature Dr. J. Sutbrinks M.D. Medical Examiner.

Date signed 5/23/47

VS 191

"LEAVE WRITING" NG INK. Every item of correct age is especially important. Physicians: please write the causes of death clearly and legibly.

652009

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. 652009

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Sts
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4714 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank August Hornig Sr.

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Helen M. Hornig

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 24, 1878

8. AGE: Years 68 | Months 8 | Days 29 | If less than one day hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Motion Picture Theater Owner

11. Industry or business

FATHER
12. Name Paul A. Hornig
13. Birthplace Germany

MOTHER
14. Maiden Name Pauline ?
15. Birthplace Germany

16 (a) Informant Mrs. Helen M. Hornig
(b) Address 4714 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/27/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAY 24 1947 (Date received by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23rd 1947, at 4:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/27/47 to 5/23/47 and that I last saw h[illegible] alive on 5/23/47.

Immediate cause of death	Duration
Heart failure	
Due to: a. C.V. Disease b. Cerebral Emb.	26 days
Due to: Adenocarcinoma of prostate	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Gonzalez

Address Maryland Gen. Hospital Date signed 5/24/47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52010

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193a

Registered No. G52010

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1009 S. Robinson St.
(c) Hospital or institution: 1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1009 S. Robinson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herman Redemann

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-03-4401

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband~~ or wife Margaret Catherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 18th 1874

8. AGE: Years	Months	Days	If less than one day
73	3	5	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Herman Redemann
13. Birthplace Hanover, Germany

MOTHER
14. Maiden Name Wilhelmina Ralthof
15. Birthplace Hanover, Germany

16 (a) Informant Margaret C. Redemann
(b) Address 1009 S. Robinson St.

17 (a) Burial (b) Date thereof 5/26/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Moreland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1317 St. Paul St.

19 (a) MAY 24 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23rd 1947, at 2:25 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 6 1947 to May 23 1947 and that I last saw him alive on May 23 1947.

Immediate cause of death	Duration
ac. Myocard. Lis	Unknown
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. A. Rosenblatt M. D.
Address 3018 O'Donnell St. Date signed 5-24-47

VS 150

G52011 Edward J. Caines 200 N. 33rd St.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G52011

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 Rogers Avenue
(c) Hospital or institution:
Home for Aged of the Methodist Church
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 Rogers Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma C. Loane

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife J. Albert Loane
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11, 1866

8. AGE: Years	Months	Days	If less than one day
81	0	10	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name August Joesting
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Rewwer
15. Birthplace Germany

16 (a) Informant Records - Methodist Home
(b) Address 2211 Rogers Avenue

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 5/24/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director WM. COOK, INC.
(b) Address 1217 St. Paul Street

19 MAY 24 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21, 1947, at 4:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to May 21 1947 and that I last saw h. alive on 5-21 1947.

Immediate cause of death Carcinoma of thigh — Duration 5 mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arthur J. Davies M.D.
M. D.
Address 2004 Eutaw Pl. Date signed 5-22-47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52012

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1336

Registered No. G52012

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Dana St
(c) Hospital or institution: Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1125 N. Gilmor St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Perkins.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	B	widowed

6 (b) Name of husband or wife Lou

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Morton Perkins
13. Birthplace Va

MOTHER 14. Maiden Name Frances ?
15. Birthplace Va.

16 (a) Informant Harris
(b) Address 2607 Spellman Road

17 (a) Burial (b) Date thereof 5 26 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Richmond, Va
Location Va

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Prestman St

19 (a) MAY 24 1947 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-22 1947, at 6.29 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-22 1947 to 5-22 1947, and that I last saw h[illegible] alive on 5-22 1947.

Immediate cause of death Cardiac Failure

Due to Uremia

Due to renal damage

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. H. Vaughan M.D.
Address Univ. Hospital Date signed 5-23-47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2013

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. C52013

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2024 Division St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Viola Clark

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: B | 6 (a) Single, married, widowed, or divorced: D

6 (b) Name of husband or wife: Huey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1908

8. AGE: Years: 39 | Months | Days | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation domestic

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant William Clark
(b) Address 2024 Division St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/26/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Wm. H. Nelson
(b) Address 1303 Pennsylvania Ave

19 MAY 24 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1947 at 4 40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/22 1947 to 5/22 1947 and that I last saw h[illegible] alive on 5/22 1947

Immediate cause of death	Duration
(a) Cardiac Failure	
Due to (b) Carcinoma of Liver	
Due to (c) Diabetes Mellitus	
Other Conditions Varicosities	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Gastric Ulcer Duod

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. R. [illegible] M. D.
Address Union Hosp. Date signed 5/23/47

VS 150

X

052014

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G52014

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 232 Arlington Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 232 N. Arlington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa Rich

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Fem | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Clarence Rich

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 5 1893

8. AGE: Years 53 | Months 7 | Days 15 | If less than one day hr. min.

9. Birthplace Balto., Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Peter Seibert

FATHER 13. Birthplace Balto, Md

MOTHER 14. Maiden Name Mary ?

MOTHER 15. Birthplace Balto Md

16 (a) Informant Clarence Rich

(b) Address 232 Arlington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-25-47 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Mt Auburn

Location Balto, Md

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N Schroeder St

19 (Date rec'd by registrar) MAY 24 1947 Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/20 1947 at 2 52 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/18 1947 to 5/20 1947 and that I last saw her alive on 5/20 1947.

Immediate cause of death	Duration
Cerebral Embolism	2 D
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. N Hofstetter M. D.

Address 1 W Pleasant Date signed 5/20/47

Acco. 5-31 1938

G52015

HEALTH DEPARTMENT—CITY OF BALTIMORE

G52015

CERTIFICATE OF DEATH

1310a

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1016 W Fayette St., Ward)

Registered No.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred....yrs....mos....ds. How long in U.S. If of foreign birth?....yrs....mos....ds.

2. FULL NAME Joseph Bradford

(a) Residence: No. 1016 W Fayette St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

3a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Silvia Bradford

6. DATE OF BIRTH (month, day, year) July 12, 1887

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40	8	9	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Laborer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Maryland

FATHER

13. NAME Joseph Bradford

14. BIRTHPLACE (city or town) (State or country) Md

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (city or town) (State or country) Unknown

17. INFORMANT Silvia Bradford
(Address)

18. BURIAL, CREMATION, OR REMOVAL
Place Mt. Auburn Date 5-26- 1947

19. UNDERTAKER Mrs Katie A. Williams
(Address) 322 N Schroeder St.

20. MAY 24 1947 Huntington Williams, M.D.
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) May 21, 1947

22. I HEREBY CERTIFY, That I attended deceased from May 1, 1947, to May 21, 1947

I last saw him alive on May 21, 1947, death is said to have occurred on the date stated above, at 2:40 p.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Renal Complication	7
Chronic hypertension	1

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis?.....Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide?.....Date of injury....., 19....

Where did injury occur?.....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?.....If so, specify

(Signed) H Bettencourt M. D.

(Address) 632 W Franklin St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G52016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G52016

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A. A.
(c) City or town Hanover
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Queen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col.	Married

6 (b) Name of husband or wife Thomas B. Queen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5, 1914

8. AGE: Years	Months	Days	If less than one day
33	1	15	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation H.W.
11. Industry or business

FATHER
12. Name Edward Johnson
13. Birthplace A-A Co Md

MOTHER
14. Maiden Name Eleanora Briggs
15. Birthplace A-A Co Md

16 (a) Informant Thomas Queen
(b) Address Kelly Bottom A A Co Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 24 1947 (month) (day) (year)
(c) Cemetery or crematory St. Mark
Location Anne Arundel Co Md

18 (a) Funeral director Mrs Kate R Williams
(b) Address 322 N Schroeder St

19 (a) MAY 24 1947 (Date received) Williamsport, Md. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-20- 1947, at 5:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-19- 1947 to 5-20- 1947, and that I last saw her alive on 5-20- 1947

Immediate cause of death Diabetic Gangrene — Duration

Due to Diabetes Mellitus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles Waddams M.D.
Address University Hospital Date signed 5-20-47

VS 150

G52017

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G52017

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2311 N. Calvert St.
(c) Hospital or institution: ----------
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) About 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ----------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2311 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? ---------- (Yes or No)
If yes, name country ----------

3 (a) FULL NAME Rebecca Sedwick Johnson

3 (b) If veteran, name war ----------
3 (c) Social Security Account No. ----------

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband ~~if wife~~: Bernard L. Johnson
6 (c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) Feb. 16, 1868

8. AGE: Years 79 | Months 3 | Days 7 | If less than one day --- hr. --- min.

9. Birthplace Calvert County, Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name Joseph Peterson Sollers
13. Birthplace Calvert County, Md.

MOTHER
14. Maiden Name Mary Elizabeth Sedwick
15. Birthplace Calvert County, Md.

16 (a) Informant Miss E. Elizabeth Johnson
(b) Address 2311 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/26/47 (month) (day) (year)
(c) Cemetery ~~######~~ Green Mount
Location Baltimore, Md.

18 (a) Funeral director H. H. Mears & Son
(b) Address 805 N. Calvert St.

MAY 24 1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 1947 at 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1929 to May 23 1947 and that I last saw h~~im~~er alive on May 22 1947.

Immediate cause of death: Coronary Thrombosis — Duration: 1 day

Due to: ----------

Due to: ----------

Other Conditions: Arteriosclerosis, Black Diabetes
(Include pregnancy within 3 months of death)

Date of operation: ----------

Major findings of operation: ----------

of autopsy: ----------

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ----------
(b) Date of occurrence ---------- at ---------- M
(c) Where did injury occur? ----------
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ---------- While at work? ----------
(Specify type of place)
(e) Means of injury ----------

23. Signature Zach. R. Morgan M.D.
Address 10-D Eager St. Date signed 5/24/47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G52018

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 503 McMachen
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 503 McMachen St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George P. Bailey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Col

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years 57 | Months | Days | If less than one day hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER

12. Name Richard Bailey

13. Birthplace Va

14. Maiden Name Margret Taylor

15. Birthplace Va.

16 (a) Informant Ella G. Bailey

(b) Address 503 Mc Machen St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-24-47 (month) (day) (year)

(c) Cemetery or crematory Mt Calvery Cem

Location Brooklyn Md

18 (a) Funeral director Elroy O. Watson

(b) Address 008 Broadway

(c) Registered by registrar (b) Signature of registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-20-47 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-19 1947 to 5-21 1947 and that I last saw h[illegible] alive on 5-21 1947.

Immediate cause of death — Duration

Cerebral Hemorrhage

Due to Arteriosclerosis 2 yr

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Atwell Jones M. D.

Address 5-5-4 Eutaw Pl Date signed 5-23-47

VS 150

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52019

BALTIMORE CITY HEALTH DEPARTMENT X G52019 Registered No.

CERTIFICATE OF DEATH V 1346

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Jessup (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EBENEZER BROOKS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Col

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ida Brooks

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years 75 Months Days If less than one day hr. min.

9. Birthplace Anne Arundel Co. Md. (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER 12. Name William H. Brooks

13. Birthplace Md.

MOTHER 14. Maiden Name Mary Brooks.

15. Birthplace

16 (a) Informant Ida Freeland Brooks

(b) Address Jessup Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 (month) 23 (day) 1947 (year)

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director Elroy A Watson

(b) Address 1000 Brant Ave

19 (a) MAY 28 1947 (b) by registrar Washington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-22 1947, at 5:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-10 1947 to 5-22 1947 and that I last saw him alive on 5-22 1947

	Duration
Immediate cause of death Uremia	
Due to Hypertrophy of prostate	
Due to	
Other Conditions Vesical Calculi	

(Include pregnancy, within 3 months of death)

Date of operation 5-14-47

Major findings of operation: Enlarged prostate & Vesical calculi

If autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

Signature Robert L Jackson

Address Provident Hosp Date signed 5-24-47

VS 150

G52020

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G52020 Registered No. 153

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Park Drive & 31st St.
(c) Hospital or institution: U.S. Marine Hospital, Balto., Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days): 11½ mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Va. (b) County:
(c) City or town: Avalon
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: Sydnor, Shelton Matthew

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife: Katie Clark
6 (c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): Dec. 12, 1874

8. AGE: Years	Months	Days	If less than one day
72	5	12	hr. min.

9. Birthplace: Richmond Co., Va. (Town, county, and state)
10. Usual Occupation: Captain
11. Industry or business: Seafarer

FATHER
12. Name: Sam Sydnor
13. Birthplace: Richmond Co., Va.

MOTHER
14. Maiden Name: Mary Hudson
15. Birthplace: Richmond Co., Va.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 5/25/47 (month) (day) (year)
(c) Cemetery or crematory: Smithland
Location: Northumberland Co. Va.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul St.

MAY 28 1947 (b) e'd by registr

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 24, 1947, at 12 n M

21. I certify that death occurred on the date above stated; that I attended deceased from June 7, 1946 to May 24, 1947, and that I last saw him alive on May 24, 1947

Immediate cause of death: Exfoliative dermatitis — Duration: 1 yr.

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: H. E. Halden, M. D.
Address: US Marine Hospital Date signed 5/24/47

X

G52021

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G52021 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert - Saratoga
(c) Hospital or institution: Mercy 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1930 Mt. Royal Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard M. Lee — Howard Hall Macy Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary May Butler Lee

6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) Aug 14 1873

8. AGE: Years 73 | Months 9 | Days 10 | If less than one day: hr. min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Benjamin Franklin Lee
13. Birthplace Balto.

MOTHER
14. Maiden Name Catherine Ford
15. Birthplace Balto.

16 (a) Informant Mrs. Mary May Butler Lee
(b) Address 1930 Mt. Royal Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 26, 1947 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location Pikesville, Md.

18 (a) Funeral director Keller Lamonaco
(b) Address 3510 Liberty Heights Ave.

19 (a) Filed (Registrar) MAY 26 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1947, at 8 35 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 1947 to May 24 1947 and that I last saw h/m alive on May 24 1947

Immediate cause of death: Respiratory failure — Duration

Due to Cerebro-vascular accident

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David M. Hills Jr. M.D.
Address Mercy Date signed May 24 1947

3 3564 G52022 E Biltmore Rd

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V33a

Registered No. G52022

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 111 S. Fulton Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 111 S Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Primrose

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 2 - 1864

8. AGE: Years	Months	Days	If less than one day
83	2	20	hr. min.

9. Birthplace Baltimore Md.
(Town, county and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER 12. Name William G. Primrose
13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Margaret E. Daecker
15. Birthplace Baltimore Md.

16 (a) Informant Miss Nellie Primrose
(b) Address 111 S. Fulton Ave.

17 (a) Burial (b) Date thereof May 26 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Baltimore

18 (a) Funeral director Maurice Cook Sypes
(b) Address 1600 W. North Ave

19 (a) (b)
(Date rec'd by registrar) Registrar

MAY 25 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1947, at 12:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 17 1947 to May 22 1947, and that I last saw h[illegible] alive on May 22 1947.

Immediate cause of death	Duration
Influenzal Bronchopneumonia	6 days
Due to	
Due to	
Other Conditions Thrombophlebitis	3

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. B. Schreiber
Address 54 S Fulton Ave Date signed 5 M. D. 27

G52023

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G52023

B'M# 980831 160c

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Rayner Ave 16

(c) Hospital or institution West Balto Gen. Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 2262 Cedleyed (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Ronald Edward Benton

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/1/47

8. AGE: Years | Months | Days | If less than one day 7 hr. 15 min.

9. Birthplace (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Upton Benton

13. Birthplace Baltimore

MOTHER 14. Maiden Name Rose Pindell

15. Birthplace Baltimore

16. (a) Informant

(b) Address 2262 Cedleyed

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/3/47 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet

Location Frederick Ave

18 (a) Funeral director Geo Reynbach

(b) Address 5 W Lexington St Baltimore, Md

JUN 2 - 1947 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 1947 at 2:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/1/47 19 to 6/1/47 19, and that I last saw h[illegible] alive on 6/1/47 19

Immediate cause of death	Duration
(a) Autopsy	
Due to asphyxia pallida	
Due to possible compression of cord	
Other conditions single fracture	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Thos Son S. Waldron

Address W B C H Date signed 6/4/47 D.

X

G52024

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G52024 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Leniversity Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 611 Warner Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lillie Brown

3 (b) If veteran, name war: None

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years 53 | Months | Days | If less than one day hr. min.

9. Birthplace Calvert Co. Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name David Hardy
13. Birthplace Calvert Co. Md.

MOTHER
14. Maiden Name Sally Hardy
15. Birthplace Calvert Co. Md.

16 (a) Informant Alice Pailen
(b) Address 824 Peach Orchard Lane

17 (a) (Burial, cremation, or removal) (b) Date thereof 5 26 47 (month) (day) (year)
(c) Cemetery or crematory Mt. Lafayette Cemetery
Location Balto. Md.

18 (a) Funeral director Hall & Pangaro
(b) Address 139 W. Hamburg St. Baltimore, Md.

19 (a) Filed MAY 26 1947 (b) Registered by (Signature) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23, 1947, at 11 30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cardiovascular-renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D. Medical Examiner.
Date signed 5-23-47

G52025 BH 72698

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1578

Registered No. G52025

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 920 Hanover St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Oeka

3 (b) If veteran, name war — (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-7-47

8. AGE: Years	Months	Days	If less than one day
	2	15	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER 12. Name Herbert Oeka
13. Birthplace Pa.

MOTHER 14. Maiden Name Nellie Rickert
15. Birthplace Md.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 5/26/47 (month) (day) (year)
(c) Cemetery or crematory MT. OLIVET
Location FREDERICK, MD

18 (a) Funeral director JOHN F. DENNY, INC.
(b) Address 765 LIGHT St.

19 (a) MAY 26 1947 (Date rec'd by registrar) Livingston Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1947, at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 12 1947 to May 22 1947 and that I last saw him alive on May 22 1947

Immediate cause of death	Duration
Respiratory failure	10 min.
Due to Meningitis	1 day
Due to Meningocoele	life
Other Conditions Spina Bifida	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert J. Sheldon M.D.
Address Date signed May 23 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52026

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓83a

Registered No. G52026

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1605 N. Hilton Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1605 N. Hilton Street (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Harry Schanze

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	212-16-3128

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Florence E. Schanze
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Nov. 9, 1869

8. AGE: Years	Months	Days	If less than one day
77	6	14	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Mercantile Trust Co.

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Miss Margaret Rhine
(b) Address 1605 N. Hilton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/26/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

19 (a) MAY 26 1947 (Date received by registrar)
Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23, 1947 at 6.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1-1940 to 5-23-1947 and that I last saw him alive on 5-23-1947.

Immediate cause of death	Duration
Hypostatic Pneumonia	2 days
Due to Coronal Thrombosis	3 mo.
Due to Arterio Sclerosis	—
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howard F. Warren M. D.
Address 107 Garrison Blvd Date signed 5-24-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52027

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1312

Registered No. G52027

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Pasadena
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Vincent Demma

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
NO	217-01-5578	M	W	M

6 (b) Name of husband or wife Mary Demma
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Nov. 30, 1893

8. AGE: Years	Months	Days	If less than one day
53	5	25	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Steel Worker
11. Industry or business Bethlehem Steel Co

FATHER
12. Name Anthony Demma
13. Birthplace Italy

MOTHER
14. Maiden Name Maria Cross
15. Birthplace Italy

16 (a) Informant Mary Demma
(b) Address Pasadena, Md

17 (a) Burial (b) Date thereof 5/28/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

19 (Date rec'd by registrar) MAY 26 1947 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/25 1947, at 1:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/18 1947 to 5/25 1947, and that I last saw him alive on 5/25 1947.

Immediate cause of death	Duration
Resp. failure	
Due to Uremia	
Due to Chronic nephritis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature August Kral M. D.
Address Mercy Hosp. Date signed 5/25/47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52028

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G52028 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raymer Ave and Dukeland St
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 37 days
(e) Length of stay in Baltimore (yrs., moe., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2326 W. Lor Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katie A Metzel

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Louis A Metzel
6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) May 9 1873

8. AGE: Years 64 | Months — | Days 9 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Emory Murray
13. Birthplace —

MOTHER 14. Maiden Name Anna Lister
15. Birthplace —

16 (a) Informant Louis A Metzel
(b) Address 2326 W Lor Ave

17 (a) Mt Olivet (Burial, cremation, or removal) (b) Date thereof May 28 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore Md

18 (a) Funeral director Butler & Sons
(b) Address 222 W Baltimore St

19 MAY 26 1947 (Date rec'd by registrar) (c) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1947, at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 9 1947 to May 26 1947 and that I last saw h e v alive on May 25 1947.

Immediate cause of death Coronary artery disease — Duration 10 weeks

Due to Arteriosclerotic cardiovascular disease — 4 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Donald F. Gleason M. D.
Address 2834 St Paul St Balto-18, Md Date signed 5-26-47

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52029

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

Registered No. G52029

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5314 Gwynn Oak Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5314 Gwynn Oak Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN FRANCIS BRADY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Annie M. Brady
(nee Wright) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23, 1868

8. AGE: Years	Months	Days	If less than one day
79	0	0	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business American Building

FATHER
12. Name Samuel Brady
13. Birthplace Balto.

MOTHER
14. Maiden Name Budget Hayes
15. Birthplace Prince Geo. Co.

16 (a) Informant Mrs. Annie M. Brady
(b) Address 5314 Gwynn Oak Ave.

17 (a) Burial (b) Date thereof 5/27/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAY 26 1947 (b) Huntington Williams, M.D.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23, 1947, at 6:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1947 to MAY 23 1947, and that I last saw h IM alive on MAY 23 1947.

Immediate cause of death CARDIAC FIBROSIS

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Allen S. Bantham M. D.
Address 3139 E BALTIMORE Date signed 5-23-47

V S 190

X

G52030

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 150

Registered No. G52030

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3115 Presbury St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3115 Presbury St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH R. THOMAS

3 (b) If veteran, name war –

3 (c) Social Security Account No. –

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife George R. Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 5, 1857

8. AGE: Years 89 | Months 5 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation –

11. Industry or business –

FATHER
12. Name George W. Summalt
13. Birthplace Baltimore

MOTHER
14. Maiden Name Margaret L. Kirsch
15. Birthplace Baltimore

16 (a) Informant Miss Delma S. Thomas
(b) Address 3115 Presbury St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/26/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (c) MAY 26 1947 Registrar Huntington Wilkinson, M.D. Address 222 d Garrison Blvd Date signed May 26/47

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22, 1947, at 8:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946 to May 22 1947 and that I last saw h-- alive on May 22 1947

Immediate cause of death Carcinoma of lungs — Duration about 1 yrs.

Due to Metastasis from right breast and epithelioma — about 3 yrs.

Due to

Other Conditions Myocarditis — 6 mo.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hattie Strebler M. D.

G52031

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registration No. G52031

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 436 S. Augusta Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 436 S. Augusta Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lewis Kernmann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Clara S. Kernmann nee Schmidt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12, 1888

8. AGE: Years	Months	Days	If less than one day
58	11	11	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Lewis Kernmann
13. Birthplace Md.

MOTHER
14. Maiden Name Rose Siehler
15. Birthplace Germany

16 (a) Informant Mrs. Clara S. Kernmann
(b) Address 436 S. Augusta Ave.

17 (a) Burial (b) Date thereof May 26/47.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Rd.

18 (a) Funeral director Harry H. Whitte
(b) Address 4101 Edmondson Ave.

19 MAY 26 1947 (b) Huntington Williams, M.D.
(Date rec'd by Local Reg.)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 1947, at 1:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 24 1942, to May 23 1947, and that I last saw h in alive on May 23 1947

	Duration
Immediate cause of death: Right Cerebral Hemorrhage	6 hrs.
Due to: Cardio-renal-vascular Disease	5 yrs.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J M Wilson M. D.
Address 617 W. 40th St. Date signed 5/24/47

V S 150

G52032

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

Registered No. G52032

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 701 Rosedale St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 701 Rosedale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Glaser

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: May J. Glaser
nee Eline

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22, 1889

8. AGE: Years 57 | Months 10 | Days ● | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Ass't Freight Agent

11. Industry or business B. & O. R. R.

FATHER
12. Name Louis Glaser
13. Birthplace Germany

MOTHER
14. Maiden Name Amelia Nunnithal
15. Birthplace Germany

16 (a) Informant Mrs. May J. Glaser
(b) Address 701 Rosedale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 26/47. (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location 5502 Frederick Rd.

18 (a) Funeral director Harry H. Lutzke
(b) Address 4101 Edmondson Ave.

19 (Date received by registrar) MAY 26 1947 (Registrar) Huntington Woods, Md.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1947, at 1 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1945 to May 1947
and that I last saw h[illegible] alive on May 22 19 47

Immediate cause of death Carcinoma of Left Lung with Metastasis to Stomach — Duration 2 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. G. Lally M. D.
Address 3511 Edmondson Ave. Date signed May 27 1947

X

G52033

BALTIMORE CITY HEALTH DEPARTMENT

GM 110346 **CERTIFICATE OF DEATH** 47e

Registered No. G52033

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern AVE.
(c) Hospital or institution: Baltimore City Hospitals 51
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 117 N. Front St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Carson, Joseph ~~Herold~~ Carol

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23 1896

8. AGE: Years	Months	Days	If less than one day
50	9 (10)	23 (20)	hr. min.

9. Birthplace Penna. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Carson
13. Birthplace Tenn.

MOTHER
14. Maiden Name Lorette Cline
15. Birthplace Penna.

16 (a) Informant Records balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-27-47 (month) (day) (year)
(c) Cemetery or crematory Morelandale Cem.
Location Balto Co. Md.

18 (a) Funeral director Leonard J. Kirsch
(b) Address 4315 Harford Rd

19 (a) MAY 26 1947 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 - 1947, at 10.05PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 - 1947 to May 23 - 1947 and that I last saw h im alive on May 23 - 1947

Immediate cause of death	Duration
Respiratory failure	
Due to Bronchogenic Carcinoma Rmetastasis	
Due to Gradually Enl. Supraclavicular lymph nodes.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Bronchogenic Ca
of autopsy: Rmetastasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature W. Dwyle Waldron
Address U. C. H. Date signed 5/24/47 M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52034 Dr. Krumrein
722 N. Kenwood

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. G52034

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 712 N. Streeper St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 712 N. Streeper St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theresia Zink

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Peter Zink
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 27, 1872

8. AGE: Years	Months	Days	If less than one day
74	4	26 27	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name George Frederick Ahles
13. Birthplace Germany

MOTHER
14. Maiden Name Eva S. Gerst
15. Birthplace Germany

16 (a) Informant Mrs. Marie Roche
(b) Address 3015 White Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/27/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 (a) MAY 26 1947 (Date rec'd by registrar) (b) Registrar

V S 190

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23rd, 1947, at 7 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1946, to May 23 1947, and that I last saw h[illegible] alive on May 22 1947.

Immediate cause of death	Duration
Carcinomatosis	June 1/46
arterial Hypertension - mitral insuff.	
Due to arteriosclerosis.	
Due to —	
Other Conditions —	

Hemiplegia anemia from hemorrhage
(Include pregnancy within 3 months of death)
Date of operation April 1-1946-
Major findings of operation: Carcinoma - Bowel - Rectal - Sigmoid junction
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis J. Krumrein M. D.
Address 722 N. Kenwood Ave Date signed May 23/47

G52035

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G52035

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 621 Stewart St
(c) Hospital or institution: City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 278 N. Marlin Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RAYMOND HUDSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Helen Hudson
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) June 4- (1887)

8. AGE: Years	Months	Days	If less than one day
59	4	19	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Bethlehem Steel
11. Industry or business

FATHER
12. Name John Hudson
13. Birthplace Md

MOTHER
14. Maiden Name Elizabeth Hornsey
15. Birthplace Md

16 (a) Informant Mrs Helen Hudson
(b) Address 278 N Marlyn Ave

17 (a) Burial (b) Date thereof May 27
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Rural

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St
(c) MAY 26 1947 Huntington Williams
(Date rec'd by registrar)

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/23/47 19 at 4:54 P.M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to 890 hrs death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Hypertensive Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D.
Medical Examiner.
Date signed 5/24/47

X

G52036

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓166

Registered No. G52036

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9. hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 502 S. Paca Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUIS COOPER

3 (b) If veteran, name war

3 (c) Social Security Account No. 241-14-2408

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12, 1917

8. AGE: Years	Months	Days	If less than one day
30	2	11	hr. min.

9. Birthplace Georgia (Town, county, and state)

10. Usual Occupation Soldy Cpl Bethlehem

11. Industry or business Steel Corporation

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Addie Johnson
(b) Address 502 South Paca Stret

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 28 1947 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn Cemetery
Location Baltimore city

18 (a) Funeral director Joseph A Lisby
(b) Address 660 West Bane Street

19 MAY 26 1947 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23, 1947, at 9.25 a M

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Bullet Wound of Chest & Abdomen

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-22-47 at 12 p. M.
(b) Where did injury occur? Fremont & Denver Sts. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Firearms

23. Signature Emil L Rego M.D. (Medical Examiner)
Date signed 5-23-47

VS 181

G52037

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V. 138

Registered No. G52037

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: 1138 Russell St
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1138 Russell St (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME John Savage

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 28, 1899

8. AGE: Years	Months	Days	If less than one day
47	8	24	..... hr. ..... min.

9. Birthplace Calvert Co Md (Town, county, and state)
10. Usual Occupation Steamfitter
11. Industry or business

FATHER
12. Name Benyom Savage
13. Birthplace Calvert Co Md

MOTHER
14. Maiden Name Annie Powell
15. Birthplace Calvert Co Md

16 (a) Informant Ada Parker
(b) Address 1138 Russell St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/26/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy A. Watson
(b) Address 1000 Hanover Ave Hanover Pa

MAY 26 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 1947 at 11 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1947 to May 24 1947 and that I last saw him alive on May 15 1947

Immediate cause of death	Duration
Respiratory failure	
Due to Tuberculosis (pulmonary)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation.....
of autopsy.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....(Specify type of place)
(e) Means of injury.....
23. Signature J. Shorofsky M.D.
Address 601 N. Monroe St. Date signed 5/26/47

V S 150

G52038

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓61

Registered No. G52038

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 39 W. Preston St.
(c) Hospital or institution:
Home 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) -
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
✓ City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 39 W. Preston St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country no

3 (a) FULL NAME Howard M. Phillips

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Amy Grace
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3, 1880

8. AGE: Years	Months	Days	If less than one day
67	0	21	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Harold B. Phillips
13. Birthplace Va.

MOTHER
14. Maiden Name Emma F. Scharf
15. Birthplace Baltimore

16 (a) Informant Mrs. Amy G. Phillips
(b) Address 39 W. Preston St.

17 (a) Burial (b) Date thereof May 27-
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Greenmount

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul St.

19 MAY 26 1947 (Date received) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1947; at 3 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/7 1947 to 5/24 1947 and that I last saw him alive on 2-3 1947.

Immediate cause of death	Duration
Coronary thrombosis	2 days
Due to Arteriosclerosis	6-8 yrs.
Due to Diabetes	20 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry D. McCarty M.D.
Address 87 W. Preston St. Date signed 5/24/47

X

G52039
AB-110470

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓ 61

G52039
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 15

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11days
(e) Length of stay in Baltimore (yrs., mos., or days) 1yr-or Life ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3610 Clifton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Vincent Cohee

3 (b) If veteran, name war	3 (c) Social Security Account No.
?	?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 28- 1905

8. AGE: Years	Months	Days	If less than one day
41	4	19	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Painter
11. Industry or business

FATHER
12. Name Robert Cohee
13. Birthplace Maryland

MOTHER
14. Maiden Name Lillian Smith
15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 5/26/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Baltimore, Maryland
18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY
19 (a) MAY 26 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1947, at 12.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-6 1947 to 5-17 1947, and that I last saw him alive on 5-17 1947.

Immediate cause of death Respiratory failure — Duration

Due to HCVD & anemia

Due to

Other Conditions Diabetes Mellitus
Anamnesis.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Doyle Waldron M.D.
Address B. C. H. Date signed 5/24/47

93D

G52040

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G52040

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor Ave. & Dukeland St.
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1229 Ashburton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Florence P. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife Fridemond
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 19 1876
8. AGE: Years 71 | Months 4 | Days 3 | If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Jimmy Cuffs
13. Birthplace England

MOTHER
14. Maiden Name Not Known
15. Birthplace

16 (a) Informant F. Smith
(b) Address 743 - E. 36th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/26/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location

18 (a) Funeral director Wayne F. Hoffman
(b) Address 1639 Broadway

19 (a) MAY 26 1947 (By the city registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 19 47, at 8:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 14, 19 47 to May 22, 19 47 and that I last saw h[illegible] alive on May 22, 19 47.

Immediate cause of death: Cardio-respiratory failure — Duration
Due to: Pulmonary edema
Due to: Hypertensive arteriosclerotic cardiovascular disease
Other Conditions: Obesity, Cholelithiasis, Bronchopneumonia, Uterus adherent
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leon Toby M.D.
Address West Balto. Gen. Hosp. Date signed 5/23/47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52011

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G52011 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2204 E Baltimore St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2204 E Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leah Miller

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Late Hyman Louis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation
11. Industry or business House Wife

FATHER
12. Name Harry J Snyder
13. Birthplace Russia

MOTHER
14. Maiden Name Nettie J ?
15. Birthplace Russia

16 (a) Informant Mrs Lottie Jacobson
(b) Address 2204 E Baltimore St

17 (a) Burial (b) Date thereof May 27, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave Rosedale

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 MAY 26 1947 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION 7.15

20. DATE OF DEATH May 23, 1947 at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/22 1947 to 5/23 1947 and that I last saw h[illegible] alive on 5/23 1947.

Immediate cause of death	Duration
a Acute Dilatation of Heart	one week
Due to Carcinoma of Ventricle of Heart	2
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. J. Jacobson M. D.
Address 20 N Mellon Date signed 5/24/47

VS 150

G52012

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G52012

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1101 N. Patterson Park Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond Rucker. Also known as Roman Reiko

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. 213-07-0204

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Ida.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-1-1894

8. AGE: Years	Months	Days	If less than one day
52	7	23	hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation JANITOR
11. Industry or business STEEL

FATHER
12. Name John Rucker.
13. Birthplace Russia.

MOTHER
14. Maiden Name Mary E.
15. Birthplace Russia

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address Records.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof MAY, 27, 1947 (month) (day) (year)
(c) Cemetery or crematory ST. ANDREWS RUSSIAN
Location A.A. COUNTY, Md.

18 (a) Funeral director Walter Brooke Bundley
(b) Address 1922 W. North ave.

19 MAY 26 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May - 24 1947, at 2. A M

21. I certify that death occurred on the date above stated; that I attended deceased from May-24 1947, to May-24 1947, and that I last saw him alive on May-24 1947

	Duration
Immediate cause of death Myocardial infarction, Acute	12 hrs
Due to arteriosclerotic heart disease	?
Due to	
Other Conditions Tuberculosis, inactive	7 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Eugene Meyer II M. D.
Address Johns Hopkins Hosp. Date signed May 24 47

VS 150

G52013

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G52013

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 836 Williams St
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 836 Williams St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis N. Karangelen

3 (b) If veteran, name war: Ex Service Man
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife:
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 6/1917
8. AGE: Years 29 | Months 11 | Days | If less than one day hr. min.
9. Birthplace Greece (Town, county and state)
10. Usual Occupation Merchant
11. Industry or business

FATHER
12. Name Nicholas Karangelan
13. Birthplace Greece

MOTHER
14. Maiden Name Panagoulias Mineakes
15. Birthplace Greece

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address Baltimore
17 (a) (Burial, cremation, or removal) (b) Date thereof 5/27/47 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Windsor Mill Rd.
18 (a) Funeral director Lannahan Funeral Home Inc
(b) Address 438-440 E. North Ave Baltimore Md
19 (a) MAY 26 1947 (Registrar's signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-23 1947, at 735 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-23 1947 to 5-23 1947 and that I last saw h[illegible] alive on May 23 1947

	Duration
Immediate cause of death Massive intra-cranial hemorrhage - Left	24 hrs
Due to Hemorrhage into ventricle	
Due to Unknown cause	
Due to	
Other Conditions Splenomegaly	

(Include pregnancy within 3 months of death)
Date of operation May 23, 47
Major findings of operation: As above
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Eugene Traeger M.D.
Address Johns Hopkins Hosp Date signed May 27 1947

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52014

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

G52014 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3519 Chestnut Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 18 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) 16
(d) Street No. 3519 Chestnut Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary F. Ness

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife William D. Ness
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/15/1863

8. AGE: Years 83 | Months 9 | Days 10 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Jacob Alban
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Elmer Ness
(b) Address 3519 Chestnut Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 28, 1947 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Baltimore, Md.

18 (a) Funeral director Frank W. Leif
(b) Address 844 West 36th St.

MAY 26 1947 (Date rec'd by registrar)

19 (a) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 19 47 at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 31 19 47 to May 25 19 47, and that I last saw h. or alive on May 25 19 47.

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to Cardio-renal-vascular Disease	5 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. N. Williams M. D.
Address 617 W. 40th St. Date signed 5/26/47

X

G52015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G52015

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2320 Etting st
(c) Hospital or institution:
MD
(d) Length of stay in hospital or inst. (yrs., mos., or days) [illegible]
(e) Length of stay in Baltimore (yrs., mos., or days) 15 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2320 Etting st
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth McElveen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	M.

6 (b) Name of husband or wife Charles Williams

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Jl. 1890

8. AGE: Years	Months	Days	If less than one day
57	3		hr. min.

9. Birthplace N. Carolina
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Henry Bond
13. Birthplace N.C.

MOTHER
14. Maiden Name
15. Birthplace [illegible] N.C.

16 (a) Informant Chas. Williams
(b) Address 2320 Etting St

17 (a) Burial (b) Date thereof 5/27/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary
Location Md

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Pressman St

19 (Registrar's record) MAY 26 1947 Huntington Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-23-47 19..., at 8:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-5- 1947, to 5-25- 1947, and that I last saw h-r alive on 5-23- 1947.

Immediate cause of death	Duration
Cerebral Thrombosis	2
Due to Coronary Clot	2
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis L. Mann M. D.

Address 2340 Montrose Av. Date signed 5-26-47

X

G52016

513279.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered No. G52016

PLEASE WRITE PLAINLY, WITH UNFADING INK—Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1552 Rialto St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles to Johnson.

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-12-3835

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Black	Married

6 (b) Name of husband or wife Victoria
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) 4-16-95.

8. AGE: Years	Months	Days	If less than one day
52	1	8	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Freight Handler.
11. Industry or business

FATHER
12. Name John Johnson
13. Birthplace ?

MOTHER
14. Maiden Name Annie ?
15. Birthplace ?

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address Records.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-27-47 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Md

18 (a) Funeral director George H. Nelson
(b) Address 1303 Presstman St

19 (c) MAY 26 1947 Huntington West Virginia
(Delivered to registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May-24 1947, at 3 M

21. I certify that death occurred on the date above stated; that I attended deceased from April-10 1947 to May-24 1947 and that I last saw him alive on May-24 1947

Immediate cause of death Uremia, Hemorrhage, fecal vaginal fistula, incontinence — Duration 2 wks

Due to post operative Complications — 3 wks

Due to exploratory laparotomy - ureterovesicostomy for Carcinoma of bladder — 4 wks

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 26 March 1947

Major findings of operation: Carcinoma of bladder

of autopsy: and peritonitis, fecal fistula, fistula

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William Hyman M. D.

Address 1 W. Mt. Royal Ave Date signed 24 May 47

PHYSICIAN

Underline the cause to which death should be charged statistically.

VS 150

652017

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 652017

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland DOA
(b) Street address
(c) Hospital or institution: South Balto General
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Rural Elevation Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. Millersville Md R.D.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James F. Fentz

3 (b) If veteran, name war: W.W.I
3 (c) Social Security Account No. 216-05-2750

4. Sex: M
5. Color or race: W
6 (a) Single, (married), widowed, or divorced. Anne Fentz
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec 11, 1892
8. AGE: Years 54 | Months 5 | Days 14 | If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Newspaper Carrier
11. Industry or business Balto News American

FATHER
12. Name James F. Fentz
13. Birthplace Balto Md

MOTHER
14. Maiden Name Anna E. Nichols
15. Birthplace Balto Md.

16 (a) Informant Audrey Fentz
(b) Address Elevation Md
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 28, 47 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie, Md
18 (a) Funeral director Thomas W. Singleton
(b) Address Glen Burnie Md
19 MAY 26 1947 (Date received by Registrar) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1947, at 3:25 P M

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D. Medical Examiner.
Date signed 5/26/47

G52018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83B

G52018 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1475 Etenesom St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1475 Etenesom St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) **FULL NAME** Cora Cooke

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex F. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife John Cooke
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12 1866

8. AGE: Years 80 | Months 10 | Days 12 | If less than one day ... hr. ... min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name George Davis
13. Birthplace Balto Md

MOTHER 14. Maiden Name Margaret Sterling
15. Birthplace Balto Md

16 (a) Informant Miss Bertie Cooke
(b) Address 1475 Etenesom St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 27 47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cemetery
Location Reisterstown Highway

18 (a) Funeral director Evans Funeral Home
(b) Address 1216 N. Charles St

19 (a) ... (b) ...
MAY 26 1947 Registered by registrar ... Livingston Williams MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-24-47 19 ..., at 855 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1st 1946 to 5-24-47 19 ..., and that I last saw her alive on 5-24-47 19 ...

Immediate cause of death Terminal bronchopneumonia Followed with Paresis of upper extremity (Carotid Chambris) Due to Carotid Arteriosclerosis. — Duration 2-3yrs

Due to ...

Due to ...

Other Conditions ...
(Include pregnancy within 3 months of death)

Date of operation ...

Major findings of operation: ...

of autopsy: ...

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ...
(b) Date of occurrence ... at ... M
(c) Where did injury occur? ... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work? ... (Specify type of place)
(e) Means of injury ...

23. Signature R. Smyth MD

Address 642 North Blvd Date signed 5-27-47

X

G52049

BALTIMORE CITY HEALTH DEPARTMENT

BH# B 79145 CERTIFICATE OF DEATH 159

G52049 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 631 N. Robinson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 12 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 631 N. Robinson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dee Maria Cavallaro

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24, 1947

8. AGE: Years | Months | Days | If less than one day 12 hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation #

11. Industry or business —

FATHER 12. Name Evarist Vincent Cavallaro
13. Birthplace Balto., Md.

MOTHER 14. Maiden Name Jean Eliz. Hershfield
15. Birthplace Balto., Md.

16 (a) Informant Evarist Vincent Cavallaro
(b) Address 631 N. Robinson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/26/47 (month) (day) (year)
(c) Cemetery or crematory Locust Point
Location Hanover Shoe Rd. Lilly & Zeiler Rep.

18 (a) Funeral director
(b) Address 403 S. Wolfe St

19 (a) (b)
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1947 at 11:46 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 24 1947 to 19, and that I last saw her alive on May 24 1947.

Immediate cause of death Premature delivery — Duration —

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. C. Schlund

Address 447 N. Kenwood Ave Date signed 5/26/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

G52050

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1186a

Registered No. G52050

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Ave
(c) Hospital or institution: St. Agnes Hosp. 27
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 14 Kirkleigh Villa (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME HERMA BELLE MORROW

3 (b) If veteran, name war ---

3 (c) Social Security Account No. ---

4. Sex Female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife William F. Morrow

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 2, 1864

8. AGE: Years 82 | Months 9 | Days 22 | If less than one day ... hr. ... min.

9. Birthplace Green Castle, Pa. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Edward Fisher (dec'd)
13. Birthplace Quincy, Pa.

MOTHER
14. Maiden Name Martha F. Cromadefer (dec'd)
15. Birthplace Quincy Pa.

16 (a) Informant Kirkleigh Villa
(b) Address 4301 Roland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/27/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location

18 (a) Funeral director Chas. J. Evans Sons Inc.
(b) Address 118 N. Mt. Royal Ave

19 (a) (Registrar) Registrar

MAY 26 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/24 1947, at 10:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/25 1947 to 5/24 1947, and that I last saw her alive on 5/24 1947.

Immediate cause of death:	Duration
Cerebral Embolism	
Fracture - Right Femur	
Due to	
Due to	
Other Conditions Fracture Pelvis	

(Include pregnancy within 3 months of death)

Date of operation 4/28/47

Major findings of operation:

Coag. Cyst Ovary + Fracture

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 4/25/47 at M
(c) Where did injury occur? Kirkleigh Villa (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? and
(e) Means of injury Tripped on Rug

23. Signature D.W. Mitchell M.D.
Address [illegible] Date signed 5/27/47

C.J. Lubinski MD / for H.B. Merrill MD

G52051
A48607

BALTIMORE CITY HEALTH DEPARTMENT X
CERTIFICATE OF DEATH V157E

G52051
Registered No.

Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Watson
(If outside city or town limits, write RURAL and give town)
(d) Street No. ?
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Fleming

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-3-44

8. AGE: Years	Months	Days	If less than one day
3	2	22	hr. min.

9. Birthplace W. Va. ?
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Harry Fleming
13. Birthplace W. Va. R

MOTHER
14. Maiden Name Helen Vincent
15. Birthplace W. Va.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) BURIAL (b) Date thereof 5-26-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory FAIRMONT
Location W. VA.

18 (a) Funeral director John O Mitchell & Son
(b) Address 206 Eutaw Pl.

MAY 29 1947 (b)
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25- 1947 at 11 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-25- 1947 to 5-25- 1947 and that I last saw him alive on 5-25- 1947

Immediate cause of death	Duration
Respiratory failure	10 min
Due to Cerebral Thrombosis	2 hrs
Due to Congenital Heart Disease	Unk
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert J. Sheldon M. D.
Address Date signed 5/26/47

G52052

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183 B

G52052 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd St. & Guilford Ave.
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 100 W. Univ. Parkway (If rural-give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME John Oakley Spencer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/6/57

8. AGE: Years	Months	Days	If less than one day
89	10		hr. min.

9. Birthplace —, Pennsylvania (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Henry Spencer
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Sarah Smith
15. Birthplace New Jersey

16 (a) Informant Hospital Records
(b) Address 33rd St. & Guilford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 27 1947 (month) (day) (year)
(c) Cemetery or crematory Lupton Cemetery
Location Lupton Pa.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1960 Eutaw Place
(c) 1947 (b) Washington Williamsport, Md. (Date fee'd by registrar) (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24, 1947, at 10 50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 13, 1947 to May 24, 1947, and that I last saw h. alive on May 24, 1947.

Immediate cause of death	Duration
Cerebral hemorrhage	?
	?
Due to Cerebral arteriosclerosis	?
Due to	
Other Conditions Bronchopneumonia	4 days.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature George W. Mitchell
Address 1960 Eutaw Pl. Date signed 5/26/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52053

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G52053 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dept.
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 126 S. Eden St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Ryan Mary Ryan

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife John Ryan

6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Dec. 9th., 1864

8. AGE: Years	Months	Days	If less than one day
82	5	16	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name ? Driver
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Lillie M. Royston (Daughter)
(b) Address 3017 Lavinder Ave. Parkvil

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/28/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. North Avenue

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) MAY 26 1947 (Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/25 1947 at 1 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic
C V disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. G. Jablonski M.D.
Medical Examiner.
Date signed 5/25/47

X

G52054

BALTIMORE CITY HEALTH DEPARTMENT

TN. 100713

CERTIFICATE OF DEATH

V13B

Registered No. G52054

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 1- 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1316 W. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Irvin J. Grey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 4th 1885

8. AGE: Years	Months	Days	If less than one day
61	8	21	hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Gray
13. Birthplace Va.

MOTHER
14. Maiden Name Alice Carson (D
15. Birthplace Maryland ?

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/26/47 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore Co. Md.

18 (a) Funeral director Wilmer Cook & Son
(b) Address 2411 E. Fayette St.

19 (a) MAY 26 1947 (Date rec'd by registrar) Huntington Millington M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25th 1947, at 8.55 A.M. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 18th 46 to May 25th 1947, and that I last saw h. im alive on May 25th 1947

Immediate cause of death: Respiratory failure

Due to: Pulmonary Tbc.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Dougle Waldron M. D.
Address B.C.H. Date signed 5/25/47

G52055

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G52055

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 208 N Payson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 208 N Payson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Dunn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Edward C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 18, 1887

8. AGE: Years 60 | Months 4 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation House work

11. Industry or business at home

FATHER
12. Name Arthur Mc. Kenna
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary A Lynch
15. Birthplace Baltimore Md

16 (a) Informant Mr Edward C. Dunn
(b) Address 208 N. Payson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/28/47 (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Road

18 (a) Funeral director John F. Cowan & Son
(b) Address 1203 Collins St

19 (a) Filed MAY 26 1947 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/24/1947, at 11:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1946 to May 24 1947.
and that I last saw her alive on May 24 1947.

Immediate cause of death Coronary thrombosis — Duration

Due to

Due to Intramedastinal C.V. Lesion

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John F. Carbohan M. D.
Address 24 W. Franklin St Date signed 5/24/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52056

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51B

Registered No. G52056

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3320 W. Rogers Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 - 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3320 W. Rogers Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE HARDY ARMSTRONG

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Charlotte Church Armstrong
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 13, 1868

8. AGE: Years	Months	Days	If less than one day
78	11	12	hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual Occupation: Printer
11. Industry or business: Self

FATHER
12. Name: Samuel Armstrong
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Catherine Hardy
15. Birthplace: Balto., Md.

16 (a) Informant: Mr. G. Hardy Armstrong
(b) Address: 3320 W. Rogers Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/28/47 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet Cem.
Location: Balto., Md.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) MAY 26 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/25 1947, at 3P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945 to 5/25 1947 and that I last saw h[illegible] alive on 5/25 1947

Immediate cause of death	Duration
pulmonary [illegible]	
Due to arteriosclerosis	
Due to Carcinoma of prostate	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 3/17/47
Major findings of operation: Obliterating carcinoma of spine
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard W Wilson M. D.
Address 5721 York Rd Balto 12 Date signed 5/25/47

V S 150

G52057 B64241 BALTIMORE CITY HEALTH DEPARTMENT X 1190 Registered No. G52057

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Raymer
(c) Hospital or institution West Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 35 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Linthicum Heights (If outside city or town limits, write RURAL and give town)
(d) Street No. Nursery Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT L. WOODEN MYERS, Jr.

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec. 8, 1946
8. AGE: Years | Months: 5 | Days: 17 | If less than one day: hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Robert L. W. Myers, Sr.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Grace M. Wehn
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Robert L. W. Myers, Sr.
(b) Address Linthicum Heights, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 27, 1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (c) MAY 26 1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 May 1947, at 12:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 10 1947 to May 25 1947 and that I last saw him alive on May 25 1947.

Immediate cause of death Disseminated of undetermined etiology — Duration 25 Days
Due to
Due to
Other Conditions Uterine media bilateral
(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy: Enlarged Kidneys, Liver.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Harold F. Gleason M. D. 1940
Address 2834 St Paul St Date signed 25 May

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C52058

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

A13B

C52058 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 651 W Fairmount Ave.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 651 W. Fairmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Shirley Kennedy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1936

8. AGE: Years	Months	Days	If less than one day
11			hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant ?
(b) Address

17 (a) Burial (b) Date thereof 5/26/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 916 Druid Hill Ave

19 (a) MAY 26 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1947 at 12:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Miliary tuberculosis of lungs. (f)
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mellenis, M.D.
Medical Examiner.
Date signed 5/22/47

VS 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52059

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 87c

Registered No. G52059

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2075 Rockrose Avenue
(c) Hospital or institution: Ardleigh Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Montgomery
(c) City or town Kensington (If outside city or town limits, write RURAL and give town)
(d) Street No. 38 Montgomery Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert O. Retner

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Blanche E. Retner
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct. 15 1879
8. AGE: Years 67 | Months 7 | Days 9 | If less than one day ___ hr. ___ min.
9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Manufacture
11. Industry or business Retired 10 years

FATHER
12. Name David O. Retner
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Garrett, Laurel
15. Birthplace Pennsylvania

16 (a) Informant David O. Retner
(b) Address Kensington, Maryland

17 (a) Burial, cremation, or removal: Burial (b) Date thereof: May 26 1947 (month) (day) (year)
(c) Cemetery or crematory: Gaithersburg
Location: Gaithersburg Pennsylvania

18 (a) Funeral director: Duvall Funeral Home
(b) Address: 3631 Falls Road

19 (a) Date received: MAY 26 1947 (b) Registrar: Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1947, at 10:05 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h__ alive on ____ 19__.

Immediate cause of death: Hypostatic Pneumonia — Duration: 3 days
Due to:
Due to:
Other Conditions: Parkinson's Disease
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward L. Heussner, M.D.
Address 2027 Falls Rd. Date signed 5/26/47

G52060

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

Registered No. G52060

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2817 Remington Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2817 Remington Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL HAZLEWOOD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22, 1917

8. AGE: Years	Months	Days	If less than one day
30 24	-	1	hr. min.

9. Birthplace Blackstone, Va
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Samuel Hazlewood
13. Birthplace Blackstone

MOTHER
14. Maiden Name Rosie Stoke
15. Birthplace Blackstone, Va

16 (a) Informant Rosie Hazlewood
(b) Address 2817 Remington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 27, 1941 (month) (day) (year)

(c) Cemetery or crematory Mt Nem
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 2214 Schroeder St

19 (a) MAY 26 1941 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/22/41 19, at 2 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pulmonary Tuberculosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Dawson M.D.
Medical Examiner.
Date signed 5/24/41

VS 151

G52061
AB-110624

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1336

Registered No. G52061

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9days
(e) Length of stay in Baltimore (yrs., mos., or days) 25yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 517 N. Bruce St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: William Lomax

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 8- 1875

8. AGE: Years	Months	Days	If less than one day
71	7	4 14	hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Lomax
13. Birthplace Va.

MOTHER
14. Maiden Name Fannie (D
15. Birthplace Va.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 27, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St.

19 (a) Date received MAY 26 1947 (b) Registrar Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22- 1947, at 10.35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-13 1947 to 5-22 1947, and that I last saw h. im alive on 5-22 1947.

Immediate cause of death: Respiratory Failure

Due to: Bronchopneumonia, Unilateral.

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: autopsy Bilateral renal cortical necrosis

of autopsy: ✓ bronchopneumonia

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm R Scarborough

Address Balto City Hosp. Date signed M. 5-22-47 D.

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G52062

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. G52062

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 79272
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 4 5
(e) Length of stay in Baltimore (yrs., mos., or days) 56 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city limits, write RURAL and give town)
(d) Street No. 903 Pierce St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Robinson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife Jerome Robinson
6 (c) If married, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 15-1874

8. AGE: Years	Months	Days	If less than one day: hr.	min.
72	?	?		

9. Birthplace Essex Co. Va. (City, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Churchill White
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records Balto. City Hospitals
(b) Address

17 (a) Burial (Burial, cremation, or removal) 4940 Eastern Ave. (b) Date thereof May 27 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 MAY 26 1947 (b) [illegible] Washington Hill Baltimore

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 - 1947 ; at 3.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 18 1945 to May 23 1947 and that I last saw h alive on May 23 1947

Immediate cause of death	Duration
Renal failure	
Due to Pyelonephritis	
Due to Unknown cause	
Other Conditions ① Metastatic Carcinoma of breast ② Generalized arteriosclerosis	

(Include pregnancy within3 months of death)

Date of operation
Major findings of operation:
of autopsy: See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edwin C. Evans M. D.
Address Balto. City Hospitals Date signed 5-23-47

VS 150

133a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52063 110855

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124 B

Registered No. G52063

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern AVE.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 207 N. Fremont ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Matthews, Wilmer

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-05-8570

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	cC	Married

6 (b) Name of husband or wife Bertha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22 1904

8. AGE: Years	Months	Days	If less than one day
43	3	1	hr. min.

9. Birthplace Baltimore MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Matthews
13. Birthplace Baltimore MD?

MOTHER
14. Maiden Name Hattie Matthews
15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-28-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. City

18 (a) Funeral director Charles R. Law
(b) Address 202 Madison Ave.

19 MAY 26 1947 (Date rec'd by registrar) Registrar Washington, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 - 1947 at 5.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 22 - 1947 to May 23 - 1947, and that I last saw h[im] alive on May 23 1947.

Immediate cause of death Peritonitis, cause undetermined. — Duration

Due to

Due to

Other Conditions Pleural Effusion ? Hemochromatosis. Cirrhosis. (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. R. Fowble, M. D.
Address Balto City Hosp. Date signed 5-23-47

X

G52064

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G52064

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1405 W. Lafayette
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1405 W. Lafayette
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Ulysses Burrell
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: C
6 (a) Single, married, widowed, or divorced: W
6 (b) Name of husband or wife: Lavinia Burrell
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 15, 1894
8. AGE: Years 53 Months 0 Days 9 If less than one day hr. min.
9. Birthplace Whitestone Va. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James Burrell
13. Birthplace Va.

MOTHER
14. Maiden Name Minnie Burrell
15. Birthplace Va.

16 (a) Informant Mabel Scott
(b) Address 1405 W. Lafayette
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/27/47 (month) (day) (year)
(c) Cemetery or crematory LORRAINE PARK
Location BALTIMORE MD. PARK
18 (a) Funeral director CHARLES R. LAW
(b) Address 502 MADISON AVE.
19 (a) MAY 26 1947 (Date rec'd by registrar) Huntington Wilkerson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1947, at 1:15 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from May 5 1947, to May 24 1947, and that I last saw alive on May 24 1947.

Immediate cause of death: General Carcinomatosis — Acute Myocarditis — Duration: 6 months, 1 day
Due to: Carcinoma of Stomach — 1 yr.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Wm. L. Berry M. D.
Address 1420 E. Chase Date signed 5-26-47

VS 150

G52065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

✓ G52065 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6319 Fait Avenue
(c) Hospital or institution:

4b

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6319 Fait Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET (MAGGIE) RODEN

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John H. Roden

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 23, 1874

8. AGE: Years 72 | Months 7 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George Nagler
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Weskey
15. Birthplace Baltimore, Md.

16 (a) Informant Samuel Roden - son
(b) Address 6319 Fait Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/27/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY

19 (a) [illegible] by registrar [illegible]

MAY 26 1947
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1947, at 10.4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1-1946 to 5-24 1947 and that I last saw h[illegible] alive on 5-23-1947

Immediate cause of death (a) Coronary Thrombosis — Duration 8 mo

Due to (b) Mitral Insufficiency — yrs ?

Due to (c)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature N. J. Dinsd M. D.
Address 3218 Eastern Ave. Date signed

X

G52066

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

Registered No. G52066

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Howard St.
(c) Hospital or institution: Maryland Gen'l Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 dis.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 425 Forest St. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Italy

3 (a) FULL NAME Mrs. Rosa Guerriero

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband xxxxx late Giovanni

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 12 1876

8. AGE: Years 69 | Months 3 | Days 11 | If less than one day hr. min.

9. Birthplace Campobello di Mazzara Italy (Town, county, and state)

10. Usual Occupation house wife

11. Industry or business home

FATHER
12. Name Domenico Stallone
13. Birthplace Italy

MOTHER
14. Maiden Name Elisabetta Cusimano
15. Birthplace Italy

16 (a) Informant Pet Guerriero (Son)
(b) Address 425 Forrest St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 27 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (a) MAY 26 1947 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 1947 19 at 6.25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/21 1947 to 5/23 1947 and that I last saw h.e.r. alive on 5/23 1947.

	Duration
Immediate cause of death Stroma	2 dis
Due to Intestinal Obstruction	6 dis.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ernest A. Cerasano M. D.
Address Md Gen'l Hosp Date signed 5/23/47

VS, 150

G52067

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G52067 Registered No.

CERTIFICATE OF DEATH 47a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 316 days
(e) Length of stay in Baltimore (yrs., mos., or days): 316 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: NY (b) County:
(c) City or town: Brooklyn (If outside city or town limits, write RURAL and give town)
(d) Street No.: 181 Columbia St. (If rural give location)
(e) Citizen of foreign country? yes (Yes or No) If yes, name country: Spain

3 (a) FULL NAME: Peter Rodriguez Lopez

3 (b) If veteran, name war:
3 (c) Social Security Account No.: 094-12-9029

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife:
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 4, 1874

8. AGE: Years	Months	Days	If less than one day
72	5	21	hr. min.

9. Birthplace: Ferral, Spain (Town, county, and state)
10. Usual Occupation: Merchant Seaman
11. Industry or business: Seafarer

FATHER
12. Name: John Lopez
13. Birthplace: ? Spain

MOTHER
14. Maiden Name: Antonia Vernandes
15. Birthplace: ? Spain

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial, cremation, or removal
(b) Date thereof: 5/29/47 (month) (day) (year)
(c) Cemetery or crematory: Evergreen
Location: Penn Grill
18 (a) Funeral director: William J. Dore
(b) Address: 1219 E. Pratt St.

MAY 26 1947 Washington Millennium

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 25 1947, at 8 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 13 1946 to May 25 1947 and that I last saw h im alive on May 25 1947

Immediate cause of death: Pneumonia, bronchial, bilateral — Duration: UNKNOWN

Due to: Postoperative state, total laryngectomy for carcinoma of larynx — Duration: 8 mos.

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation: 9-19-46
Major findings of operation: Carcinoma of larynx
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon
Address: Clinical Director Date signed: 5/26/47

G52068

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48

Registered No. G52068

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 339 Rosebank Av
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 339 Rosebank Av (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence L. Smith

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Roy B.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 25-1873
8. AGE: Years 74 | Months 3 | Days 1 | If less than one day hr. min.
9. Birthplace Claremont Ill. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business "

FATHER
12. Name Timothy Gilmor
13. Birthplace Monroe Ill.

MOTHER
14. Maiden Name Hattie Nason
15. Birthplace Claremont Ill.

16 (a) Informant Suzanne Glass
(b) Address 339 Rosebank Av

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof May 27-47 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Oliver & Greenmount Ave

18 (a) Funeral director John A. Hogan
(b) Address 3000 E. Balto. St.

MAY 27 1947 (Date received) (Registrar) Curtis for Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1947, at 9 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 7 1946 to May 26 1947 and that I last saw h. alive on May 26 1947.

Immediate cause of death: Adeno-Carcinoma fundus uteri — Duration: 4 yrs.
Due to —
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation February 1946
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. A. Chaffant M. D.
Address 6210 York Rd Date signed May 28, 47

X

G52069

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G52069

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1409 Cliftview Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1409 Cliftview Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry F. Seipple

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Pearl Seipple
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4 1877

8. AGE: Years	Months	Days	If less than one day
69	10	21	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Lazenby

FATHER
12. Name (Unknown) Seipple
13. Birthplace

MOTHER
14. Maiden Name Catherine Hutz
15. Birthplace Germany

16 (a) Informant Pearl Seipple
(b) Address 1409 Cliftview Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/28/47 (month) (day) (year)
(c) Cemetery or crematory U.S. National
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) Date received MAY 27 1947 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1947, at 3:20 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 1947 to May 24 1947, and that I last saw h[illegible] alive on May 4 1947.

Immediate cause of death	Duration
Cerebral Apoplexy	1 hour
Due to Hypertension.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. F. Schmeisser M. D.
Address 701 N. Rosedale Date signed May 27, 1947

VS 150

G5-2070

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. G5-52070

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1410 Battery Ave.
(c) Hospital or institution: 24 3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1410 Battery Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Florence M. White

3 (b) If veteran, name war: W

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: William White

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1881

8. AGE: Years: 66 | Months: 3 | Days: 11 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name: Christopher Schemm

FATHER — 13. Birthplace: Baltimore, Maryland

MOTHER — 14. Maiden Name: Katherine Ehrich

MOTHER — 15. Birthplace: Germany

16 (a) Informant: Charles C. Schemm

(b) Address: 2716 Fenwick Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-28-47 (month) (day) (year)

(c) Cemetery or crematory: Baltimore

Location: Forth Ave.

18 (a) Funeral director: Wm. Cook Inc.

(b) Address: 1217 St. Paul St.

MAY 27 1947 (Date rec'd by registrar)

(Washington Williams M.D. Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1947, at 8 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 5 1946 to 5/26 1947 and that I last saw h[illegible] alive on 5/25/1947.

	Duration
Immediate cause of death — Coronary Embolism	1 hr.
Due to — General Arteriosclerosis	1 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: [signature] M.D.

Address 1279 Eutaw Pl. Date signed 5/24/47

G52071

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G52071

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden + Madison Sts
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. #3 500 N. Decker Ave #13 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary C. McBride

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2.

8. AGE: Years Above 45 | Months | Days | If less than one day hr. min.

9. Birthplace Camden N. J. (Town, county, and state)

10. Usual Occupation Cafeteria

11. Industry or business Glenn L. Martin

FATHER
12. Name John McBride
13. Birthplace Ireland

MOTHER
14. Maiden Name Sarah Darrah
15. Birthplace Ireland

16 (a) Informant Catherine Eckels (Sister)
(b) Address 1500 N. Decker Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/24/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

MAY 27 1942 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26th 1947, at 5.05 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 14 1947, to May 26 1947, and that I last saw h[illegible] alive on May 26 1947.

Immediate cause of death	Duration
Heart failure	
Due to Bronchitis	
Due to Pneumonia and	12 days
Due to Left Hemiplegia	
Due to C. V. disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. E. Gonzalez
Address Maryland General Hospital Date signed 5/26/47

VS 150

G52072

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

AB-107252

CERTIFICATE OF DEATH · 13B

G52072 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr. 4mos. 22days
(e) Length of stay in Baltimore (yrs., mos., or days) 70yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 18 West Lee Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Chenowith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Lara

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4- 1870

8. AGE: Years	Months	Days	If less than one day
77	2	20	hr. min.

9. Birthplace Baltimore County, Maryland (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Benjamin Chenowith
13. Birthplace Wyoming

MOTHER
14. Maiden Name Catherine Tolbert
15. Birthplace Ireland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/27/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) MAY 27 1947 (b) Registrar
Registered by

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1947, at 7 -25P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-2- 1946 to 5-24- 1947, and that I last saw h im alive on 5-24- 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Pulmonary Tbc	
Due to	
Other Conditions A S H D	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Doyle Waldron M. D.
Address B. C. H. Date signed 5/25/47

G52073

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G52073

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 509 Gold Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 509 Gold Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RAE MASON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Donald Mason
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 14, 1898

8. AGE: Years	Months	Days	If less than one day
49	3	9	hr. min.

9. Birthplace Carroll Co., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Olive Sappington
13. Birthplace Md.

MOTHER
14. Maiden Name Fannie Dotson
15. Birthplace Md.

16 (a) Informant Mr. Donald Mason
(b) Address 509 Gold Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-27-47 (month) (day) (year)
(c) Cemetery or crematory Fairview Cem.
Location Carroll Co., Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (Date received by local registrar) (b) Huntington Williams M.D.

MAY 24 1947

V S 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH May 23, 1947, at 11:55

21. I certify that death occurred on the date above stated; that I attended deceased from 5-1 1947, to 5-23 1947 and that I last saw h[illegible] alive on 5-23 1947

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Hypertension	2 years
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis T. Hinman M. D.
Address 2340 Madison Ave Date signed 5-24-47

X

G52074

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G52074 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1116 Argyle Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1116 Argyle Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Gray

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife James Gray
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1876

8. AGE: Years	Months	Days	If less than one day
70	8	10 17	hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Rogers
13. Birthplace Virginia

MOTHER
14. Maiden Name Salley James
15. Birthplace Virginia

16 (a) Informant Mr. James Gray
(b) Address 1116 Argyle Ave.

17 (a) Burial (b) Date thereof 5-28-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co., Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

MAY 27 1947 (b) Huntington Williams, M.D.
(Date received by registrar)

V S 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH May 24, 1947, at 8:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 20 1947 to May 24 1947, and that I last saw him alive on 19

Immediate cause of death: Arteriosclerosis Cardiac
Due to Acute disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
Hope

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address Date signed 5/26/47

G57075

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G57075

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Riverside Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1514 Riverside Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence W. Walker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Lloyd G.
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) July 25, 1895

8. AGE: Years	Months	Days	If less than one day
51	9	29	hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Whitfield Webb
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Barker
15. Birthplace Va.

16 (a) Informant Family
(b) Address 1514 Riverside Ave.

17 (a) B (b) Date thereof 5/28/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave.

18 (a) Funeral director James L. McCauley
(b) Address 130 E. Fort Ave.

19 (a) MAY 27 1947 (b) Huntington-Williams M.D.
(Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1947, at 10 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1943 to May 24 1947 and that I last saw h.e.r. alive on May 24 1947.

Immediate cause of death	Duration
Cardiac	
Coronary - Infarct	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jno Tilney Thomas M. D.
Address 57 y Med. Arts Bldg Date signed May 24/47

X

G52076

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G52076

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2426 E. Fayette St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-2

(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 2426 E. Fayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY GUSTOMOLSKY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	WIDOW

6 (b) Name of husband or wife JOSEPH

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years	Months	Days	If less than one day
76			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name ABRAHAM
13. Birthplace RUSSIA

MOTHER
14. Maiden Name ANNA
15. Birthplace RUSSIA

16 (a) Informant HOWARD LANCASTER
(b) Address 2426 E. FAYETTE ST

17 (a) Burial (b) Date thereof 5-27-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Fernwood Hall Rd

18 (a) Funeral director Jenkins Sons Inc
(b) Address 1432 E. Balto St.

MAY 27 1947 Huntington Williams, M.D.
(Date received) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-25 1947, at 5:53 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1947 to 5-25- 1947, and that I last saw h[illegible] alive on 5-25- 1947.

Immediate cause of death	Duration
BRONCHO-PNEUMONIA	1 DAY
Due to [illegible] CEREBRAL THROMBOSIS	5 DAYS
Due to ARTERIOSCLEROSIS	10 YEARS
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. Benj. B. Jones M. D.
Address 448 N. Luzerne Ave. Date signed 5-26-47

VS 150

G52077

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G52077

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure to correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Greenspring Ave
(c) Hospital or institution: Levindale 15-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 3922 Edgewood Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA MUTCHNIK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: David

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years: 66 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Russia

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Russia

16 (a) Informant: Leon Cohen
(b) Address: 3922 Edgewood Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-27-47 (month) (day) (year)
(c) Cemetery or crematory
Location: Hebrew Mt Carmel

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 1439 E Balto St

19 (a) (b) Date rec'd by registrar: MAY 27 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-24 1947 at 3:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-22 1947 to 5-24 1947 and that I last saw h[illegible] alive on 5-24 1947

Immediate cause of death: Coronary thrombosis — Duration:

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Henry W Dyd M. D.
Address: Levindale Home Date signed 5-27-47

X

C52078 — C52078

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133a

Registered No. C52078

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 918 Whitelock St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Oscar Schwartz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Grocer

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace Russia

MOTHER 14. Maiden Name Unknown

15. Birthplace Russia

16 (a) Informant Rose Schwartz

(b) Address 918 Whitelock St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) 5 (day) 27 (year) 47

(c) Cemetery or crematory United Hebrew

Location Washington Boulevard

18 (a) Funeral director Jas. H. Lewis Inc

(b) Address 1464 E Balto St (Town) Baltimore Md

MAY 27 1947 (Date signed by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1947 at 4:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/19 1947 to 5/26 1947 and that I last saw h[illegible] alive on May 26 1947.

Immediate cause of death	Uremia	Duration
Due to	Pyonephrosis	
Due to		
Other Conditions	Pulmonary edema	
	Uremia. [redacted]	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Heinz Beissinger M.D.

Address Sinai Hospital Date signed 5/26/47

X

G52079

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G52079

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2 No Lakewood Ave
(c) Hospital or institution: 6-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2 No Lakewood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Aaron Roseman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years 78 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Isaac
13. Birthplace Russia

MOTHER
14. Maiden Name Mary
15. Birthplace Russia

16 (a) Informant Rose Roseman
(b) Address 2 No Lakewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-27-47 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Herzum Park

18 (a) Funeral director Jack Levin Inc
(b) Address 1409 E Balto St

(a) Date received MAY 27 1947 (b) Registrar Hamilton for Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-24- 1947, at 7:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1937 to 5-24 1947
and that I last saw him alive on 5-24 1947.

Immediate cause of death	Duration
Left Ventricular Failure	1 yr
Coronary Artery Disease	1 yr
Due to Arteriosclerosis	
Hypertension Heart Disease	10 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. Leo S. Hamilton M. D.
Address 2426 Eutaw Pl Date signed 5/27/47

X

G52080

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47F

G52080 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4613 Park Heights Ave
(c) Hospital or institution: Mt Sinai Home 22-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 39yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 14 E Montgomery St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Goldberg

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Hannah
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years 56 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name unknown
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Melvin Goldberg
(b) Address 3405 Parkington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-27-47 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Mt Carmel
18 (a) Funeral director Jack Lewis Inc
(b) Address 1409 E Balto St

(c) Date received by registrar MAY 27 1947 (d) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-25-47; at 12:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1 1947 to 5/25 1947 and that I last saw alive on 5/24 1947

Immediate cause of death: Cancer of Pedunculated — Duration

Due to: Hemorrhage

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 5/18 Inoperable

Major findings of operation: Cancer

of autopsy

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. Goldberg M. D.
Address 2225 Linden Ave Date signed 5/28/47

G57081

BALTIMORE CITY HEALTH DEPARTMENT X
CERTIFICATE OF DEATH ✓ 46a

Registered No. G57081

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct: age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave.
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mo. 15 da

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Magnolia (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George C. Brown

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Lula F. Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 26, 1883

8. AGE: Years	Months	Days	If less than one day
64	3	29	hr. min.

9. Birthplace Magnolia Md. (Town, county, and state)
10. Usual Occupation Merchant
11. Industry or business

FATHER
12. Name J. Warren Brown
13. Birthplace Magnolia Md.

MOTHER
14. Maiden Name Laura J. Knight
15. Birthplace Maryland

16 (a) Informant Lula F. Brown
(b) Address Magnolia Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 28, 194 (month) (day) (year)
(c) Cemetery or crematory Cokesbury
Location Abingdon Md.

18 (a) Funeral director Howard K. McComas & Son
(b) Address Abingdon Md.

19 (a) MAY 27 1947 (registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25, 1947, at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/10 1947 to 5/25 1947, and that I last saw h[illegible] alive on 5/24 1947

Immediate cause of death	Duration
Coronary Failure	
Due to Arteriosclerotic Heart Disease	
Due to	
Other Conditions 1. Prostatic hypertrophy with urinary retention 2. Cataracts to be operated on	

(Include pregnancy within 3 months of death)
Date of operation 5/12/47
Major findings of operation: Carcinoma of prostate
of autopsy: [illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address Sinai Hosp. Date signed M. 5-27-47 D.

G52082

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G52082

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 703 Ashburton St
(c) Hospital or institution:

16-6

(d) Length of stay in hospital or inst. (yrs., mos., or days) and
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 703 Ashburton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Betty M Regel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Theodore F. Regel
6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) May 3 / 1899

8. AGE: Years 48 | Months | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name William L Griffin
13. Birthplace Virginia

MOTHER
14. Maiden Name Cora A Lewin
15. Birthplace Maryland

16 (a) Informant Theodore F Regel
(b) Address 703 Ashburton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 29-47 (month) (day) (year)

(c) Cemetery or crematory Western Cem May 29 47
Location 115 Gloucester St

18 (a) Funeral director Charles Powell
(b) Address 1427 Edmondson Ave

(a) (b)
(Date received by Registrar) Washington Williams MD

MAY 27 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1947, at 9P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 7 1947, to May 26 1947, and that I last saw h[illegible] alive on May 26 1947

Immediate cause of death Carcinoma of Breast — Duration 5 yrs
Carcinomatosis
Due to
Due to
Other Conditions None
(Include pregnancy within 3 months of death)
Date of operation 1943
Major findings of operation: Carcinoma of Breast
of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jos Coleman M. D.
Address 120 W Lafayette Ave Date signed 5-27-47

X

G52083 W. Johnson

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G52083

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 920 Madison ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 920 Madison Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cornelia Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Williams

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1884

8. AGE: Years 63 | Months 3 | Days 13 | If less than one day ____ hr. ____ min.

9. Birthplace Pittsboro, N. Carolina
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business ?

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Yarbough
15. Birthplace

16 (a) Informant William Harris
(b) Address 929 Madison Ave.

17 (a) Burial (b) Date thereof 23 47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem
Location U. S. Route 1 Md

18 (a) Funeral director Adolphus Hall
(b) Address 918 Druid Hill Ave

19 (a) MAY 27 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25, 1947, at 8:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 20 1947 to May 25 1947 and that I last saw h[illegible] alive on May 25 1947

Immediate cause of death: Cerebral Hemorrhage — Duration: 5 days

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dan'l A. Salmon M. D.

Address 2329 Guilford Ave Date signed May 29 1947

G52084

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G52084

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Rayner Ave
(c) Hospital or institution: West Baltimore General Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2574 W. Fairmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Anton F. Plogmann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Anna (Muller)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 18, 1900

8. AGE: Years	Months	Days	If less than one day
47	1	7	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Iron Worker
11. Industry or business Distill Bros

FATHER
12. Name Franz Plogmann
13. Birthplace Germany

MOTHER
14. Maiden Name Josephine Ernisbacher
15. Birthplace Germany

16 (a) Informant Mrs Anna Plogmann
(b) Address 2574 W Fairmount Ave

17 (a) Burial (b) Date thereof May 28 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location 3201 Frederick Ave

18 (a) Funeral director Harry A Wilhelm
(b) Address 4101 Edmondson Ave

19 (a) (Date rec'd by Registrar) (b) Registrar Huntington Williams, MD

MAY 27 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1947 at 11:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 23 1947 to May 25 1947, and that I last saw h IM alive on May 25 1947.

Immediate cause of death	Duration
Acute Pulmonary Edema	
Due to Peripheral Vascular Collapse	
Due to CARCINOMA OF LIVER	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Carcinoma of Liver

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Bachmeyer M. D.
Address West Baltimore Gen'l Date signed May 27/47

X

G52085

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G52085

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2616 Eutaw St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2616 Eutaw St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Vincent Hardesty

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mary F. Hughes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 17-1888

8. AGE: Years 58 | Months 5 | Days 7 | If less than one day hr. min.

9. Birthplace Balto Md (town, county, and state)

10. Usual Occupation R.R. Conductor

11. Industry or business B + O. R.R.

FATHER
12. Name James A. Hardesty
13. Birthplace Md

MOTHER
14. Maiden Name Laura E. Harwood
15. Birthplace Md

16 (a) Informant Mrs. Mary F. Hardesty
(b) Address 2616 Eutaw St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-28-47 (month) (day) (year)
(c) Cemetery or crematory Mayo Ridge
Location Wash. Blvd.

18 (a) Funeral director Wm. J. Connelly
(b) Address 448 Eutaw Blvd

MAY 27 1947 Huntington, W. Va.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/24/1947 at 11:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/19/1947 to 5/24/1947, and that I last saw h[illegible] alive on 5/24/1947.

Immediate cause of death	Duration
Myocardial insufficiency	24 hrs
Due to Chronic Myocarditis	
Due to	
Other Conditions Asthma	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. A. Barden

Address 1518 North Ave Date signed 5/26/47 M. D.

X

G52086

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

Registered No. G52086

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1116 Eutaw St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1116 Eutaw St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary E. McMahon

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: John P. McMahon | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 3, 1866

8. AGE: Years 80 | Months 0 11 | Days 25 22 | If less than one day hr. min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual Occupation: Home wife at

11. Industry or business: Home

FATHER
12. Name: Peter Hogan
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Ellen McKenna
15. Birthplace: Ireland

16 (a) Informant: Mrs Howard McMahon
(b) Address: 1116 Eutaw St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-25-1947 (month) (day) (year)
(c) Cemetery or crematory: Mount Cathedral Cemetery
Location: 4300 Old Frederick Rd.

18 (a) Funeral director: Edward W. Carter & Son
(b) Address: 924 E. Eager St.

19 (a) Filed 5-27-1947 (Date) (year) (b) Registrar: Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25, 1947 at 3P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 17 1947 to May 25 1947 and that I last saw h[illegible] alive on May 24 1947

Immediate cause of death: Myocardial failure - Chronic myocarditis — Duration 5/17/47

Due to: arteris - Sclerosis —

Due to:

Other Conditions: acute & chronic kidney —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature: Louis H. Krumrein M. D.

Address 725 N. Kenwood Ave Date signed 5/26/47

G52087 BC# B-76110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 182a

G52087 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 16-2
(c) Hospital or institution: Maryland General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1216 Parrish St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Crosby Drummer

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/14/47

8. AGE: Years | Months: 1 | Days: 14 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER 12. Name Court Drummer

13. Birthplace Md

MOTHER 14. Maiden Name Shirley Crosby

15. Birthplace Md

16 (a) Informant Shirley Crosby

(b) Address 1216 N. Parrish St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/28/47 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Md

18 (a) Funeral director Geo. G. Kelson

(b) Address 1303 Pennsylvania Ave

19 (a) 5/27 1947 (Date received by registrar) (b) Hamilton Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1947, at 1:55 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Mechanical suffocation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 16/2

(a) Date of injury 5-25-47 at 9 A.M.

(b) Where did injury occur? 1216 Parrish St.

(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no

(d) Means of injury Probably Pedestrian

23. Signature Earl C. Royster M.D. (Medical Examiner)

Date signed 9-26-47

VS 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52088

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G52088

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 wks
(e) Length of stay in Baltimore (yrs., mos., or days) 45yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2411 E. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GALBERT A. BOUGHTER (Boughter)

3 (b) If veteran, name war —
3 (c) Social Security Account No. 212-16-6951

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Annie C. Boughter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 27, 1864

8. AGE: Years	Months	Days	If less than one day
82	3	28	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Thomas Boughter
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Tate
15. Birthplace Md.

16 (a) Informant Mr. G. Delmar Boughter
(b) Address 4379 Sheldon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 29/47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Episcopal Cem.
Location Harford Co. Md.

18 (a) Funeral director Philip Mervis Sons
(b) Address 2024 Orleans St.

19 (a) MAY 27 1947 (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1947, at 11:15 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Fracture left humerus
Fracture left tibia and fibula
Due to Fracture left ribs
Bronchopneumonia
Other Conditions Meningitis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-24-47 ? 6/3 M.
(b) Where did injury occur? Harford Ave + Fayette St
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Ped. struck by auto.

23. Signature George L. Merbell M.D.
Medical Examiner.
Date signed 5/26/47

VS 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

B/H 6-79157 — 161a — X

Registered No. G52089

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2000 Fayette St
(c) Hospital or institution:
Bon Secours Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) ✓

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Middle River Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8 Right Aileron St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Everd (EVERD)
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	W	Infant

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26, 1947

8. AGE: Years	Months	Days	If less than one day
			12 hr. min.

9. Birthplace Balto Md
(Town, county, and state)
10. Usual Occupation
11. Industry or business Infant

FATHER
12. Name Robert Edward Everd
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Mary O'Connor
15. Birthplace Balto Md

16 (a) Informant Mother
(b) Address 8 Right Aileron St
17 (a) Buried (Burial, cremation, or removal) (b) Date thereof May 27/47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore
18 (a) Funeral director Philip Hereford Sons
(b) Address 2024 Allegheny Ave

MAY 27 1947 (a) (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION 6 3/5

20. DATE OF DEATH May 26 1947 at 6 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19..., to 19..., and that I last saw h... alive on 19...

Immediate cause of death	Duration
Respiratory failure	
Due to Atelectasis	
Due to	
Other Conditions Prem	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: ?
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William F. Carr M. D.
Address Bon Secours Hosp. Date signed 6-26-42

X

G52090

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1941

Registered No. G52090

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1522 Gorsuch Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1522 Gorsuch Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Elliott England

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Female	White	Widowed

6 (b) Name of husband Joseph England

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 27, 1877

8. AGE: Years	Months	Days	If less than one day
69	9	28	hr. min.

9. Birthplace Wilmington, Del. (town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own Home

FATHER
12. Name John Elliott Thomas
13. Birthplace Cambridge, Md.

MOTHER
14. Maiden Name Laura Wilson
15. Birthplace Maryland

16 (a) Informant Joseph C. England
(b) Address Mt. Pleasant Beach

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 28, 1941 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St
(c) (Date rec'd by registrar) MAY 27 1941 (Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1941, at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 25 1941, to May 25 1941, and that I last saw her alive on May 25 1941

Immediate cause of death	Duration
Chronic myocarditis, Hypostatic congestion	6 mos.
Due to	
Due to	
Other Conditions Bronchopneumonia	5 days

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jos. Edward Brown M.D.

Address 1250 E. North Ave Date signed May 27 1941

C52091

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. C52091

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Mem Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4910 Midwood Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Roberta

3 (b) If veteran, name war — (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Joseph Willem Roberts
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23, 1874

8. AGE: Years	Months	Days	If less than one day
73	1	3	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Mr. Frederick Hallenbach
13. Birthplace ?

MOTHER
14. Maiden Name Helen Applegate
15. Birthplace New Jersey

16 (a) Informant Mrs. Edward Bauernschmidt
(b) Address 2209 Mayfield Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/29/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Balto.

18 (a) Funeral director L. J. Ruck
(b) Address 5305 Harford Rd

19 MAY 27 1947 (b) [illegible] Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1947, at 10:25 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-22 1947 to 5-26 1947 and that I last saw her alive on 5-26 1947

Immediate cause of death	Duration
Hemo pneumo thorax right	
Due to Fractured ribs right 7,8,9,10	5 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 27/10
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 5-21-47 at 9:30 p.m.
(c) Where did injury occur? Baltimore Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fell down steps

23. Signature Norman R. Freeman M. D.
Address Union Memorial Hosp. Date signed May 26 '47

VS 150

Earl R. Reynolds

G52092

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH ✓ 164a

Registered No. G52092

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) [redacted] At Sea aboard
[redacted]
Steamship McManus, (Stockard Steamship Line)
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town Suffern
(If outside city or town limits, write RURAL and give town)
(d) Street No. 78 Maltbie Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM JOSEPH SHANNON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Mabel Crowe
6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1907

8. AGE: Years	Months	Days	If less than one day
40	3	6	hr. min.

9. Birthplace Michigan
(Town, county, and state)
10. Usual Occupation Marine Engineer
11. Industry or business Merchant Marines

FATHER
12. Name William J. Shannon
13. Birthplace Unknown

MOTHER
14. Maiden Name Anna May McHugh
15. Birthplace Unknown

16 (a) Informant Mrs. Mabel Shannon
(b) Address Suffern, N.J.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 5/27/47 (month) (day) (year)
(c) Cemetery or crematory
Location Suffern N.Y.

18 (a) Funeral director Guy F. Bergen Jr
(b) Address 1512 Hollins St

MAY 27 1947 (Date rec'd by registrar) (b) [illegible] Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13, 1947, at 12:50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Mechanical suffocation

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5/13/47 at M.
(b) Where did injury occur? On board ship.
(c) Did injury occur at home, on farm, industrial place, in public place? ha While at work? Yes
Head jammed - top of door and frame
(d) Means of injury body suspended

23. Signature George H. Merrill M.D.
Medical Examiner.
Date signed 5-27-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52093

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No. G52093

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 11 N. Jeffery St 25
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1,702 Clapham Court (If rural, give location)
(e) Citizen of foreign country (Yes or No) If yes, name country
11 W. Jeffrey St

3 (a) FULL NAME Charles Hickey

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Irene Shriver
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/1/1878

8. AGE: Years 68 Months 6 Days 23 If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Railroad

FATHER
12. Name James Hickey
13. Birthplace Ireland

MOTHER
14. Maiden Name Cath Waters
15. Birthplace Md

16 (a) Informant Jas L. Hickey
(b) Address 11 N Jeffery St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/28/47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Riche Highway

18 (a) Funeral director J. J. Daly & Son
(b) Address 13 S. Light St

19 MAY 27 1947 (Date accepted by registrar) Huntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1947, at 10 25 p. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull with intracranial hemorrhage

Due to

Other Conditions Fract. 9th Dorsal Vertebra, Fracture of both tibias and fibulae (Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5/24/47 at 10 25 p. M. 25/2
(b) Where did injury occur? Hanover & Randall Sts
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Pedestrian struck by auto

23. Signature [signature] M.D. Medical Examiner.
Date signed 5/26/47

X

G52091 BCH-13508

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 104a

G52091 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2463 Brentwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2463 Brentwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert E. Lee

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/10/1947

8. AGE: Years | Months: 2 | Days: 14 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Clifton Stovall
13. Birthplace Ga

MOTHER
14. Maiden Name Helen Lee
15. Birthplace Baltimore

16 (a) Informant Helen Lee
(b) Address 2463 Brentwood ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-27-47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A.A. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 MAY 27 1947 (Date received by local registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24th 1947 at 10 45 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Upper Respiratory Infection

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Rayner M.D. (Medical Examiner)
Date signed 5-26-47

G52095

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1121a

Registered No. G52095

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 50 S. Fulton Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 50 S. FULTON AVE
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME ANNA MARY WALSH

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: FEMALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife FERDINAND M

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sep - 3 - 1885

8. AGE: Years 61 | Months 9 | Days 8 | If less than one day 24 hr. min.

9. Birthplace BALTIMORE - MD
(Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business —

FATHER
12. Name JOHN HENRY RIXSE
13. Birthplace BALTIMORE

MOTHER
14. Maiden Name RACHEL JANE SHELDON
15. Birthplace Baltimore -

16 (a) Informant SARAH RIXSE
(b) Address 50 S. FULTON AVE

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-29-47 (month) (day) (year)
(c) Cemetery or crematory Loudon PARK
Location [redacted] FREDERICK AVE.

18 (a) Funeral director THOMAS J. KENNY - INC
(b) Address 600 HOLLINS ST

19 MAY 27 1947 (b) [illegible] Washington-Williams M.D.
(Date received by Registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/27 1947, at 7:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1946 to 5/27 1947, and that I last saw h er alive on 5/27 1947.

Immediate cause of death Tuberculous Degeneration — Duration 2 yrs.

Due to Arthritis Deformans —

Due to Chronic Nephritis —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: /

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stuart E. Bygood
Address 1905 W. Baltimore Date signed 5/28/47

VS 189

G52096

AB-109656

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V13B

Registered No. G52096

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 6-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo. 22days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1738 McCubbin Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Rice

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	Col.	Married

6 (b) Name of husband or wife Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16- 1917

8. AGE: Years	Months	Days	If less than one day
30	0	9	hr. min.

9. Birthplace N.C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Sylvester Fowler
13. Birthplace N.C.

MOTHER
14. Maiden Name Mamie Faulkan or Falkan
15. Birthplace N.C.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof May 27 47 (month) (day) (year)
(c) Cemetery or crematory
Location Rocky Mount N. C.

18 (a) Funeral director Isabel L. Brown Co.
(b) Address 108 W Montgomery St

19 MAY 27 1947 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25- 1947, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-25- 1947 to 5-25- 1947, and that I last saw her alive on 5-25- 1947

Immediate cause of death	Duration
Respiratory failure	
Due to Pulmonary Tb	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Doyle Waldron M.D.
Address B. C. H. Date signed 5/25/47

X

G52097

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 132

G52097 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 649 W Lee Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days) 15

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto city (If outside city or town limits, write RURAL and give town)
(d) Street No. 649 W Lee St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Willie Jones

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Mr

6 (b) Name of husband or wife Fannie Jones
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/20/1890

8. AGE: Years 57 | Months - | Days 4 | If less than one day ... hr. ... min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Janitor
11. Industry or business News Paper Co

FATHER
12. Name [illegible]
13. Birthplace [illegible]

MOTHER
14. Maiden Name [illegible]
15. Birthplace [illegible]

16 (a) Informant Fannie Jones (W)
(b) Address 649 W Lee St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/28/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto City

18 (a) Funeral director Daniel L Brown Jr
(b) Address 108 W Montgomery St

MAY 27 1947 Washington Williams [illegible]
Date received by local registrar Signature of local registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/24/ 1947, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/22 1947 to 5/24/47, and that I last saw h[illegible] alive on 5/20/47

Immediate cause of death	Duration
Acute Myocarditis	3 days
Due to Nephritis	chronic
Due to [illegible]	5 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W D Lozier
Address 620 Edmondson Date signed 5/26/47

G52098 BALTIMORE CITY HEALTH DEPARTMENT G52098

CERTIFICATE OF DEATH ✓ 61

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution St. Joseph's 3 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 11 ds.
(e) Length of stay in Baltimore (yrs., mos., or days) 47

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 407 S. Bond (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bernadine C. Reechel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Gustave P. Reechel
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) 7-13-99

8. AGE: Years	Months	Days	If less than one day
47	10	11 12	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William E. Parks
13. Birthplace Texas Md.

MOTHER
14. Maiden Name Catherine Schreder
15. Birthplace Germany

16 (a) Informant Gustave P. Reechel
(b) Address 407 S. Ann St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-28-1947 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A. A. Co. Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

19 (Date received) MAY 27 1947 (Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25, 1947, at 3:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 7, 1947 to May 25, 1947, and that I last saw her alive on May 25, 1947.

Immediate cause of death: Cardiorespiratory failure — Duration

Due to Diabetes mellitus

Due to Diabetes with Gangrene

Other Conditions Bilateral amputation
(Include pregnancy within 3 months of death)

Date of operation April 23, 1947

Major findings of operation: Gangrene both legs

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address [illegible] Date signed 5/28/47

X

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52099

515952

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 157E

Registered No. G52099

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ohio (b) County
(c) City or town Cincamium (If outside city or town limits, write RURAL and give town)
(d) Street No. 404 W 2nd St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bonita J Brown

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-12-42

8. AGE: Years	Months	Days	If less than one day
4	10	14	hr. min.

9. Birthplace Ohio (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Howard Brown
13. Birthplace Ohio

MOTHER
14. Maiden Name Alice Ritz
15. Birthplace Ohio.

16 (a) Informant Reynolds
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof 5-29-47 (month) (day) (year)
(c) Cemetery or crematory Ithaca
Location Ithaca, Ohio

18 (a) Funeral director J. Howard Strong
(b) Address 3207 W. North Ave

19 (a) MAY 27 1947 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH May 26 1947, at 10.40 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 25 1947 to May 26 1947, and that I last saw her alive on May 26 1947.

Immediate cause of death	Duration
Post-operative Hemorrhage	12 hrs.
Due to Congenital Heart disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 5/26/47
Major findings of operation: Pulmonary stenosis
of autopsy: Tetralogy of Fallot

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Henry F. Bahnson M.D.
Address JHH Date signed 5/27/47

VS 150

G52100

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G52100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) DA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 532 Bloom Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Breckenridge

3 (b) If veteran, name war World War #1

3 (c) Social Security Account No. 216-03-1817

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. ✓

6 (b) Name of husband or wife Georgia W. Breckenridge

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 3 - 1896

8. AGE: Years 51 | Months 1 | Days 20 | If less than one day hr. min.

9. Birthplace Owings Mills Balto Co, Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John Breckenridge
13. Birthplace Owings Mills, Balto Co, Md

MOTHER
14. Maiden Name Margaret Sheridan
15. Birthplace Owings Mills Balto Co Md

16 (a) Informant William E. Breckenridge
(b) Address Randallstown, Balto Co, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-29-47 (month) (day) (year)

(c) Cemetery or crematory Baltimore National
Location Baltimore Md

18 (a) Funeral director Geo. George H. Holland
(b) Address 2616 Arnold Ave

19 (a) MAY 27 1947 (Date rec'd by registrar) (b) Huntington Williamsport, Md

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/23/47 19..., at 7:30 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Dawson M.D.
Medical Examiner.
Date signed 5/24/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

052101

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. 052101

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 month 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 62

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2415 N. Harvard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Viola Tydings

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	N	Wid

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-21-1884

8. AGE: Years	Months	Days	If less than one day
62	8 10	3	hr. min.

9. Birthplace Howard Co., Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Richard Hall
13. Birthplace Anne Arundel Co. Md

MOTHER
14. Maiden Name Martha ?
15. Birthplace Long Hill, Md.

16 (a) Informant Mrs. Lennie Dare
(b) Address 2413 N. Howard St

17 (a) Burial (b) Date thereof May 28, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Laurel Cemetery
Location Baltimore, Md.

18 (a) Funeral director Mrs. George A. Holland
(Address) MAY 27 1947 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Thomas J. Williams, M.D.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-24 1947 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-12 1947 to 5-24 1947 and that I last saw h[illegible] alive on 5-24 1947

Immediate cause of death Carcinomatosis

Due to Carcinoma of Cervix

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature I. B. Higgins / Florist
Address Provident Hospital Date signed 5-26-47

X

G52102

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G52102

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2808 Walbrook Ave.
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2808 Walbrook Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: KATHERINE ELIZABETH BRANDAU

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John P. Brandau
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 30, 1878

8. AGE: Years	Months	Days	If less than one day
68	4	26	hr. min.

9. Birthplace Baltomore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Kinsey Sparrow
13. Birthplace Hagerstown, Md.

MOTHER
14. Maiden Name Rachael Groom
15. Birthplace Hagerstown, Md.

16 (a) Informant Mrs. Ruth Brandau Jones
(b) Address 2808 Walbrook Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/29/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (c) MAY 27 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26, 1947, at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 5 1947 to May 26 1947, and that I last saw h(e)(r) alive on May 26 1947

Immediate cause of death	Duration
Cardiac failure	1 day
Due to Hypertensive Cardio-Vascular Disease	8 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. Bradley Daugherty M. D.
Address Hale Thorpe, Frdk Date signed 27 May 47

V S 150

652103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 652103

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5325 Liberty Heights Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 - 2
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5325 Liberty Heights Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LAURA LOTZ

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Wm. H. Lotz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1877

8. AGE: Years	Months	Days	If less than one day
70	4	3	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Wise
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Gart
15. Birthplace Germany

16 (a) Informant Mrs. Iona B. Reinhardt
(b) Address 5325 Liberty Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/28/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location: Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) MAY 27 1947 (Date rec'd by Registrar) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25, 1947, at 6.43 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1947 to May 25 1947 and that I last saw her alive on May 25 1947.

Immediate cause of death	Duration
1) Arterio-Sclerotic Cardio-Vascular	
Due to Disease	5yrs.
Due to	
Other Conditions Generalized Arterio-Sclerosis	5yrs.

(Include pregnancy within 3 months of death)
Date of operation None.
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Earl L. Chambers M.D.
Address 4108 Liberty Hts. Date signed 5/26/47

V S 130

G52104

BALTIMORE CITY HEALTH DEPARTMENT

Housel

CERTIFICATE OF DEATH 1638

Registered No. G52104

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts
(c) Hospital or institution: Union Memorial Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) Was Thursday
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County 5
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 615 Bernuda Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Evelyn Lulu Housel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Dead
Mr Howard 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18, 1885

8. AGE: Years 62 | Months | Days 8 | If less than one day ____ hr. ____ min.

9. Birthplace New Jersey Princeton
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name James Wright
13. Birthplace New Jersey

MOTHER 14. Maiden Name Elizabeth A Parvin
15. Birthplace New Jersey

16 (a) Informant Mrs Ruth E Jones
(b) Address 4304 Roveland Ave.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 5/28/47 (month) (day) (year)
(c) ~~Cemetery~~ or crematory Greenmount
Location Balto. Md.

18 (a) Funeral director Wm. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md.

19 MAY 27 1947 Date rec'd by reg. Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1947 at 2 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 26 1947 to May 26 1947 and that I last saw h.e.r. alive on May 26 1947

Immediate cause of death	Duration
Cerebro vascular accident	2 hrs
Due to Hypertension	
Arteriosclerosis	7 yrs
Due to	
Other Conditions Hypertension (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: Cerebral accident

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address Union Memorial Date signed

Accepted 5-28-47
937

G52105

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √131a

Registered No. G52105

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Denison St.
(c) Hospital or institution: Crawford Retreat & Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 271 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1513 No. Broadway
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Nellie Cornelia Karthen

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4 Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Horace Karthen
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 4 1863.

8. AGE — Years 83 | Months 10 | Days 27 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Charles Koons
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Snyder
15. Birthplace Germany

16 (a) Informant Wilbur J. Simpson Jr.
(b) Address 1513 No. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 29 1947 (month) (day) (year)

(c) Cemetery or crematory Lorraine Cemetery
Location Baltimore Co. Md.

18 (a) Funeral director Wilbur J. Simpson Jr.
(b) Address 1510 Liberty Heights Ave

19 (Date rec'd by registrar) MAY 27 1947 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1947 at 1 a M

21. I certify that death occurred on the date above stated; that I attended deceased from May 2 1947, to May 26 1947, and that I last saw h[illegible] alive on May 26 1947.

Immediate cause of death Coronary Thrombosis — Duration Sudden

Due to Arteriosclerotic Cardio-Vascular Renal Disease.

Due to .....

Other Conditions Hemiplegia - left. — 24 Hrs

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Joseph D. Blume M.D.
Address 1206 E. Fenton Date signed 5/26/47

VS 150

C52106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1147

Registered No. C52106

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 120 S Caroline St. -
(c) Hospital or institution:
St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 526 N Bouldin St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Alba Fletcher

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	

6 (b) Name of husband or wife William Fletcher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3 1879

8. AGE: Years	Months	Days	If less than one day
67	11	23	hr. min.

9. Birthplace La Mar - Buena (Town, county, and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER
12. Name Byron Vandersloot
13. Birthplace Pa.

MOTHER
14. Maiden Name Harriet Watson
15. Birthplace Pa.

16 (a) Informant Mr. Wm. Fletcher
(b) Address 526 N. Bouldin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/29/47 (month) (day) (year)
(c) Cemetery or crematory Silverbrook
Location Wilmington, Del.

18 (a) Funeral director John C. Mitchell Funeral Dir.
(b) Address 1920 Eutaw Place

MAY 27 1947 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1947, at 10 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 24 1947 to May 26 1947 and that I last saw her alive on May 26 1947.

Immediate cause of death	Duration
Hemorrhage from lung	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy: Multiple abscesses of lungs

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Anthony F. DiPaula M.D.
Address St. Joseph Hospital Date signed 5/26/47

G52107

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G52107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 14 Midvale Road
(c) Hospital or institution:
none 27-13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 14 Midvale Road
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Brian Parsons

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife I. Manning Parsons
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 27, 1871

8. AGE: Years	Months	Days	If less than one day
76	2	29	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Marion A. Brian
13. Birthplace Md.

MOTHER
14. Maiden Name Emily A. Creamer
15. Birthplace Md.

16 (a) Informant Mrs. Martha M. Parsons
(b) Address 800 St. George's Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/28/47 (month) (day) (year)
(c) Cemetery ~~Greenmount~~ Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 MAY 27 1947 Huntington Williams, MD
(Date filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1947, at 6.45A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 5 1946, to May 26 1947, and that I last saw h.er alive on May 25 1947

Immediate cause of death Bronchopneumonia — Duration Four days

Due to

Due to

Other Conditions Arteriosclerosis with extreme Parkinson's disease
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operations: —

of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Julius Tilden Howard M. D.
Address 12 E. Eager St. Date signed May 27, 47

VS 150

G52108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G52108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Gilmor & Willem
(c) Hospital or institution: St Agnes 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 927 Brunswick
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Rudolph Haigis
3 (b) If veteran, name war
3 (c) Social Security Account No. 216-01-7209

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Mae J Haigis
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Sept 15 1901

8. AGE: Years	Months	Days	If less than one day
45	8	10	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Supt. Toy Co.
11. Industry or business Meat Packer

FATHER
12. Name Louis Haigis
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary Wunder
15. Birthplace Balto. Md

16 (a) Informant Mrs Rudolph Haigis
(b) Address 927 Brunswick Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 29 47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director L. D. Wisgerver & Son
(b) Address 1300 Eutaw Place

19 (a) (Signature of registrar) Huntington Williams M.D.
(b) MAY 27 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/25 1947 at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/15 1947 to 5/25 1947 and that I last saw deceased alive on 5/25/1947

Immediate cause of death (Duration)
1 Cardiac failure
Due to Coronary thrombosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr W Mutzel M.D.
Address St Agnes Date signed 5/25/47 L. D.

G52109

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1242

G52109 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 5-
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 225 E. East Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Irvin Benjamin Lynch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	div.

6 (b) Name of husband or wife Pauline
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21-1911

8. AGE: Years	Months	Days	If less than one day
35	10	6	hr. min.

9. Birthplace Harford Co.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wm. B. Lynch
13. Birthplace Md.

MOTHER
14. Maiden Name Amanda Schisler
15. Birthplace Md.

16 (a) Informant Mrs. Milton Cox
(b) Address 3103 Chesley Ave

17 (a) Burial (b) Date thereof 5/30/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenlawn
Location Balto Co. Md.

18 (a) Funeral director Leonard J. Cusk
(b) Address 5325 Harford Rd.

19 (Date received by registrar) MAY 27 1947 Hunter for Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1947, at 6:40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Hemorrhage

Due to Ruptured esophageal varicosity

Other Conditions Cirrhosis of liver.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D.
Medical Examiner.
Date signed 5-27-47

G52110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BCH-78912 X 160a

Registered No. G52110

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 394 Yorkway (If rural give location)
(e) Citizen of foreign country (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Patterson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23, 1947

8. AGE: Years	Months	Days	If less than one day
			15 hrs. min.

9. Birthplace Baltimore, (Town, county, and state)

10. Usual Occupation child.

11. Industry or business

FATHER
12. Name James W. Patterson
13. Birthplace N. Carolina

MOTHER
14. Maiden Name Mary E. Evans
15. Birthplace Penn.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo MAY 27 1947

18 (a) Funeral director Commissioner of Health
(b) Address

MAY 27 1947 (Date received) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-23-47 at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-23 1947, to 5-23 1947, and that I last saw him alive on 5-23 1947.

Immediate cause of death	Duration
Intracranial Hemorrhage	
Atelectasis	
Due to Prematurity (1305 gms)	
Due to Premature Separation Placenta	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at P.M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature of D J Fuggi
Address Johns Hopkins Hosp. Date signed 5-23-47

VS 150

X

G52111

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G52111

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Kent
(c) City or town Chestertown (If outside city or town limits, write RURAL and give town)
(d) Street No. 414 Calvert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Goldsborough

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-21-47

8. AGE: Years | Months | Days 3 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name John W. Goldsborough

13. Birthplace Md.

MOTHER 14. Maiden Name Carmeta Hollins

15. Birthplace Md.

16 (a) Informant JOHNS HOPKINS HOSPITAL Records

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location Johns Hopkins Medical School MAY 27 1947

18 (a) Funeral director Commissioner of Health

(b) Address

19 MAY 27 1947 Signature for Williams M.D.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1947, at 7 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 24 1947 to May 24 1947 and that I last saw h alive on May 24 1947

Immediate cause of death	Duration
Cardiac failure	3 days
Due to	
Congenital Heart Disease	life
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert Shelden

Address Date signed 5/27/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correct as supplied. Write the causes of death clearly and legibly. Physicians: please write is especially important.

2112 DC = G92483

515740

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G52112

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2514 Eo. Druid Hill Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Kenneth Kemp.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-21-47.

8. AGE: Years | Months | Days: 6 | If less than one day: hr. min.

9. Birthplace: Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER | 12. Name Samuel Kemp.
13. Birthplace Md.

MOTHER | 14. Maiden Name Wanda Bradley
15. Birthplace Md

16 (a) Informant Records. (b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/28/47. (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Milton Schilling
(b) Address 2914 Hanover St.

MAY 27 1947 Washington Williams, M.D.
(Date rec'd by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May - 27 1947, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May - 21 1947. to May - 27 1947. and that I last saw him alive on May - 27 1947.

Immediate cause of death: Cerebral hemorrhage — Duration

Due to: Prematurity 1000 gms.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D. J. Troppy

Address Johns Hopkins Hosp. Date signed 5-M. 28-D. 47-Y.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G52113

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 13 S. Pulaski St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 13 S. Pulaski Street
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Katie Gertrude Bruns

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Ferdinand H. Bruns
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) January 17, 1887

8. AGE: Years 60 | Months 4 | Days 10 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business: Home

FATHER
12. Name: John H. Scharf
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Mary K. Wittel
15. Birthplace: Maryland

16 (a) Informant: Harry L. Bruns
(b) Address: 13 S. Pulaski Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-30-47 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Baltimore Maryland

18 (a) Funeral director: George L. Schwab
(b) Address: 2101 Frederick Avenue

19 (a) Date received by Local Registrar MAY 27 1947 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27, 1947, at 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1939 to May 27 1947.
and that I last saw her alive on May 26 1947.

Immediate cause of death: Coronary Thrombosis — Duration: ½ hr.
Due to: Arteriosclerotic Cardiovascular Disease.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:
23. Signature: Bruce Langfitt M.D.
Address: 400 N. Payson St. Date signed 5/27/47

G52111

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92a

G52111 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Cal. (b) County
(c) City or town San Francisco (If outside city or town limits, write RURAL and give town)
(d) Street No. 1518- 6th Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Trygve Botha Bertelsen

3 (b) If veteran, name war —
3 (c) Social Security Account No. 551-26-5503

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married (Mrs. AARSTAD)
6 (b) Name of husband or wife: Ingrid Johnson Bertelsen
6 (c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.) Jan. 30, 1902

8. AGE: Years 45 | Months 3 | Days 26 | If less than one day: hr. min.

9. Birthplace Norway (Town, county, and state)
10. Usual Occupation Captain
11. Industry or business Seafarer

FATHER
12. Name Bertel Bertelsen
13. Birthplace Norway

MOTHER
14. Maiden Name Elise Olsen
15. Birthplace Norway

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 5/27/47 (month) (day) (year)
(c) Cemetery or crematory Lone Mountain Funeral Home
Location 1387 Folsom St. San Francisco Calif.
18 (a) Funeral director Emil B. Hirschfeld Funeral Home
(b) Address 403-E-25th St.
19 MAY 27 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1947, at 7:50A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 21 1947 to May 26 1947 and that I last saw him alive on May 26 1947

Immediate cause of death (1) Coronary sclerosis with stenosis, right & left, myocardial infarction

Due to old and myocardial failure.

Due to (2) Calcific aortic stenosis, moderately advanced

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

Duration
UNKNOWN
UNKNOWN

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L. Wilson
Address John L. Wilson, Sr. Surgeon Clinical Director Date signed 5/26/47 M.D.

X

G52115 ~~B#~~ D78219

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 107

G52115 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT AND SARATOGA
(c) Hospital or institution:
MERCY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) TWO WEEKS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALT. (If outside city or town limits, write RURAL and give town)
(d) Street No. 631 N. CALVERT. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THEODORE T. DINGLEY.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. INFANT.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/9/47

8. AGE: Years | Months | Days: 18 | If less than one day: hr. min.

9. Birthplace BALT. MD. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name ROBERT DINGLEY.
13. Birthplace VERMONT.

MOTHER
14. Maiden Name MARGARET CAIN
15. Birthplace OHIO

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-28-47 (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Baltimore
18 (a) Funeral director George A. Bailey
(b) Address 1st Lane & Fayette St.

19 (a) MAY 28 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-27 1947, at 9:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-25 1947, to 5-27 1947 and that I last saw h. IM alive on 5-27 1947.

Immediate cause of death RESP. FAILURE. — Duration

Due to PNEUMONIA, WIDESPREAD. — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James A. Roberts M. D.
Address Mercy Hospital Date signed 5-27-47

VS 150

X

G52116

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 46F

Registered No. G52116

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla. (b) County
(c) City or town Miami
(If outside city or town limits, write RURAL and give town)
(d) Street No. 561 N.W. 63rd St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George R. Beers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna

6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) 7-19-77

8. AGE: Years 69 | Months 10 | Days 8 | If less than one day hr. min.

9. Birthplace N. J. (City, county, and state)

10. Usual Occupation Retired

11. Industry or business Amusement Business

FATHER
12. Name Thomas Beers
13. Birthplace N. Y.

MOTHER
14. Maiden Name Mary Worrell
15. Birthplace N. Y.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 5/28/47
(burial, cremation, or removal) (month) (day) (year)

(c) Cemetery Southern Memorial Park
Location Miami Florida

18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 St. Paul st.

(a) MAY 28 1947 (b) Huntington Williams, M.D.
(Date received) (Local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1947, at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 22 1947 to May 27 1947 and that I last saw him alive on May 27 1947.

Immediate cause of death	Duration
Cerebral Anoxia	14 days
Due to Cerebral Hemorrhage	14 days
Due to	
Other Conditions Carcinoma Amputation of Vulva (Include pregnancy within 3 months of death)	6 mos.

Date of operation 5/14/47

Major findings of operation: Carcinoma Amputation of Vulva

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas N P Johns M. D.
Address Johns Hopkins Hosp. Date signed

C52117

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. C52117

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3019 Northwood Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3019 Northwood Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Wallace

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Frank S

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 30. 1888

8. AGE: Years 58 | Months 7 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William M Cussan
13. Birthplace Annapolis Md

MOTHER
14. Maiden Name Margaret Thompson
15. Birthplace Gatts Md

16 (a) Informant Frank Wallace
(b) Address 3019 Northwood Drive

17 (a) Burial (b) Date thereof 5/31/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Maryland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1219 St. Paul St.

19 (a) Date received by local registrar MAY 28 1947 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1947, at 4:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/30/1942 to 5/26/1947 and that I last saw h[illegible] alive on 5/26/1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	11 hrs
Due to Hypertension Chronic C.V.D.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. Nathan F. Krumbhaar M. D.

Address 1016 S. Eutaw Date signed 5/27/47

G52118

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G52118

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 412 N. Rose St.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 412 N. Rose St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William T. Jubb

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Katie Jubb

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14, 1863

8. AGE: Years	Months	Days	If less than one day
83	11	12	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Huckster

11. Industry or business

FATHER
12. Name Lloyd Jubb
13. Birthplace Baltimore Co. Md.

MOTHER
14. Maiden Name Sarah White
15. Birthplace Don't know

16 (a) Informant Mrs. Katie Jubb
(b) Address 412 N. Rose St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 28, 1947 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.,

19 (a) MAY 28 1947 (Date received by registrar) (b) Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26, 1947 19 ..., at 6:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-21-46 19 ..., to 5-26 1947, and that I last saw h alive on 5-26-1947.

Immediate cause of death Acute Myocarditis — Duration 1 Day

Due to Arteriosclerotic Heart Disease

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benj. B. Moore, M. D.

Address 448 N. Longwood St. Date signed 5-27-47

X

G52119

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G52119 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1536 Carswell Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1536 Carswell Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES SCHMIDT

3 (b) If veteran, name war —

3 (c) Social Security Account No. 218-09-2601

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Catherine Schmidt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 27 1870

8. AGE: Years	Months	Days	If less than one day
76 7 mo	4	29	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Compositor

11. Industry or business Printing Co.

FATHER 12. Name Conrad Schmidt

13. Birthplace Germany

MOTHER 14. Maiden Name Engel

15. Birthplace Germany

16 (a) Informant Mrs. Catherine Schmidt

(b) Address 1536 Carswell Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/30/47 (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location Baltimore Md

18 (a) Funeral director Ulrich Funeral Home

(b) Address 2607 Orleans St

19 MAY 28 1947 (Date received by Registrar) (b) Huntington Williams M.D. (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/26/47 19 at 8:10 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John R. Norris M.D. Medical Examiner.

Date signed 5/27/47

G52120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 115c

Registered No. G52120

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 211 W. Hamburg St
(c) Hospital or institution: 23
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs.) mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 211 W. Hamburg St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Kelley

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	W

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/15/1885

8. AGE: Years	Months	Days	If less than one day
62	4	11	hr. min.

9. Birthplace Wilmington N. C
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Henry Thrapless
13. Birthplace N.C.

MOTHER
14. Maiden Name Emmeline ?
15. Birthplace N.C

16 (a) Informant Elizabeth Green (sis)
(b) Address 211 W Hamburg St

17 (a) Removal (b) Date thereof 5/24/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Wilmington
Location North Carolina

18 (a) Funeral director Isaiah L Brown & Co
(b) Address 108 W Montgomery

MAY 28 1947 (b) Huntington Williams, M.D.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1947 at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 22 1947 to May 26 1947 and that I last saw her alive on May 22 1947

Immediate cause of death	Duration
Pneumonia	16 days
Due to	
Myocardiosclerosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W H Wells M. D.
Address 5153 Leighton Date signed 5/28/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

Registered No. G52121

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6028 Old Hartford Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE, MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 800 GORSUCH AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAMIE A. RISTON

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	SINGLE

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) NOV. 23, 1879

8. AGE: Years	Months	Days	If less than one day
67	6	2	hr. min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name WILLIAM T. RISTON
13. Birthplace BALTIMORE, MD.

MOTHER
14. Maiden Name SARAH E. CORNS
15. Birthplace BALTIMORE, CO

16 (a) Informant MISS KATIE RISTON
(b) Address 800 GORSUCH AVE.

17 (a) BURIAL (b) Date thereof 5 28 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory MT. OLIVET
Location FREDERICK RD.

18 (a) Funeral director JOHN F. DENNY, INC.
(b) Address 715 LIGHT ST.

Filed MAY 28 1947 (b) [redacted]
(Date filed) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1947, at 4:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1947 to 5/25 1947, and that I last saw h[illegible]R alive on 5/25 1947

Immediate cause of death: Acute Myocardial Failure — Duration
Due to: Arterio Sclerosis
Due to:
Other Conditions: Old Fracture of Rt. Neck of Femur
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 28/1
(a) Accident, suicide, or homicide Accidental
(b) Date of occurrence Feb. 26, 1946 at M
(c) Where did injury occur? Mt. Hope Retreat
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public Place While at work? no
(Specify type of place)
(e) Means of injury Fell from chair to floor

23. Signature Laurence C. Peck M.D.
Address 6805 York Rd Date signed 5/27/47
Hamilton J. Mullen, M.D.

G52122

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G52122

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Hampnett Ave.
(c) Hospital or institution: Pine Ridge Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2409 Barclay St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMILY I. PRITCHARD

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: George E. Pritchard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 24, 1865

8. AGE: Years	Months	Days	If less than one day
81	7	2	hr. min.

9. Birthplace Aberdeen, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Crevenston
13. Birthplace Aberdeen, Md.

MOTHER
14. Maiden Name Sarah
15. Birthplace Aberdeen, Md.

16 (a) Informant Mrs. Frank Harten
(b) Address 2713 Woodsdale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/29/47 (month) (day) (year)
(c) Cemetery or crematory Grove Presbyterian Cem
Location Aberdeen, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

MAY 28 1947 (Date received by Registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26, 1947; at 9:20A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 5th. 1947 to May 26th 1947.
and that I last saw her alive on May 25th. 1947.

Immediate cause of death: Myocardial Insufficiency — Duration: unknown
Due to: Arteriosclerosis — about 5yrs
Due to: ---------
Other Conditions: Chronic Interstitial Nephritis — unknown
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. W. Margetrey III M.D.
Address 401 E. 25th. St. Date signed 5/27/47

V S 150

G52123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G52123

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 106 N. Carrollton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 106 N Carrollton Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie Slade

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife William Slade
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 30, 1894

8. AGE: Years 53 | Months - | Days 24 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Home Wife

11. Industry or business

FATHER 12. Name John Gaddis Jarvis
13. Birthplace Va

MOTHER 14. Maiden Name Alice Bradshaw
15. Birthplace Va

16 (a) Informant Gertrude Fagan
(b) Address 106 N. Carrollton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May (month) 28 (day) 1947 (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) [illegible] (b) Baltimore, Md

MAY 28 1947

VS 156

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1947 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/17 1947 to 5/24 1947 and that I last saw her alive on 5/23 1947

Immediate cause of death — Hypertensive Encephalopathy — Duration

Due to Hemiplegia

Due to Cerebral Hemorrhage

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 106 N Carrollton Ave Date signed 5/27/47

G5C121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

Registered No. G52121

AB-110650

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26-12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Denby

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birthdate of deceased (mo., day, yr.) April 8- 1857

8. AGE: Years: 90 | Months: 1 | Days: 23 | If less than one day: hr. min.

9. Birthplace Talbot County, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER: 12. Name

13. Birthplace

MOTHER: 14. Maiden Name

15. Birthplace

16 (a) Informant Records-Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-28-47 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Adolphus Halstead

(b) Address 918 Druid Hill Ave.

19 (a) (b) Registrar Huntington Williams, M.D.

MAY 28 1947

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 19 47, at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-14 19 47 to 5-18 19 47, and that I last saw h im alive on 5-18- 19 47.

Immediate cause of death Uremia — Duration 1 wk

Due to generalized Arteriosclerosis — yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: no P.M.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Edmund Beacham

Address Balto City Hosp Date signed 27 May 47

Released from B.C.H. 5/27/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. C52125

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 785 WEST PRATT STREET.
(c) Hospital or institution:
NO
(d) Length of stay in hospital or inst. (yrs., mos., or days) NO
(e) Length of stay in Baltimore (yrs., mos., or days) 15 YEARS

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 785 WEST PRATT STREET.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country.

3 (a) FULL NAME ANNA WILLIAMS.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 25. 187[illegible]

8. AGE: Years 67 | Months 7 | Days 0 | If less than one day ... hr. ... min.

9. Birthplace Abbille South Carolina (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name Henigor Bowens

13. Birthplace Abbille South Carolina

MOTHER 14. Maiden Name Unknown

15. Birthplace Unknown

16 (a) Informant Eulah L. Watt

(b) Address 765 W Pratt street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 29, 1947 (month) (day) (year)

(c) Cemetery or crematory Mount Calvary

Location Anne Arundel County Md

18 (a) Funeral director Joseph A. Lisby

(b) Address 661 West Lane Street

MAY 28 1947 (Date received by Registrar) (b) [illegible] for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 25 1947 19... at 7.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from APRIL 29 1947 to MAY 25 1947, and that I last saw her alive on MAY 25 1947

Immediate cause of death	Duration
ACUTE CARDIAC DILITATION MAY 25 47.	
Due to CHRONIC MYOCARDITIS.	1946.
Due to ARTERIOR SCLEROSIS	1946.
Other Conditions INTESTINAL INFLUENZA 1947	

(Include pregnancy within 3 months of death)

Date of operation NO

Major findings of operation: NONE

of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 3013 ST PAUL STREET. Date signed MAY 26 1947.

G52126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

Registered No. G52126

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 912- N. Durham Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PHILIP HEBRON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 28, 1928

8. AGE: Years	Months	Days	If less than one day
18	7	27	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Frederick Hebron
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Ethel Johnson
15. Birthplace Baltimore, Md.

16 (a) Informant Ethel Hebron
(b) Address 912- N. Durham Street.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 28, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn Md

18 (a) Funeral director Elroy A Wilson
(b) Address 1010 Beatty Ave

19 (a) MAY 28 1947 (Date rec'd by registrar) (b) Filed by Huntington Williams, MD

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 25, 1947 at 1.41 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet- wound of heart and left lung

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-25-47. about 11 p. M.
(b) Where did injury occur? Bond & Barnes- Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Firearms

23. Signature George A. Merrill M.D. (Medical Examiner)
Date signed 5-26-47

X

G52127 ✓ G52127

514346

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cost of age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1515 N. Rupsine Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Borowiak

3 (b) If veteran, name war

3 (c) Social Security Account No. YES ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Adam W.

6 (c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.) 9-27-15

8. AGE: Years	Months	Days	If less than one day
31	8	1	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Adam Parzynski
13. Birthplace

MOTHER
14. Maiden Name Frances Kowalski
15. Birthplace

16 (a) Informant Friends.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-31-47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location Baltimore County Md.

18 (a) Funeral director George R Weber
(b) Address 705 S. Ann St

19 (a) Date received by registrar MAY 23 1947 (b) Registrar Lentington Williams, M.D.

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH May - 28 1947, at 3.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April - 28 1947 to May - 28 1947 and that I last saw her alive on May - 28 1947.

Immediate cause of death	Duration
Subacute bacterial endocarditis	4 mo
Due to Streptococcus Viridens	
Due to Rheumatic Heart Dis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E. Mason M. D.
Address Johns Hopkins Hosp Date signed 28 May '47

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G52128 ✓ G52128 Registered No. 83a

G52128

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 528 N. Mowford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 528 N. Montford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James P. Cleary

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary Cleary

6 (c) If give, give age years

7. Birth date of deceased (mo., day, yr.) 6/28/1890

8. AGE: Years 56 | Months 10 | Days 30 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Maintance Man

11. Industry or business Women Hosp.

FATHER
12. Name Wm. J. Cleary
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Elizabeth Lewis
15. Birthplace Balto. Md.

16 (a) Informant Mary Cleary
(b) Address 528 N. Montford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 31-47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location Edmondson Ave

18 (a) Funeral director John J. Miller
(b) Address 2334 Jefferson St

MAY 28 1947 (Date rec'd by registrar) Faustina Williams, M.D. Registrar

VB 181

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1947, at 2 05 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subarachnoid Hemorrhage (Hypertension)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Louis Royer M.D. Medical Examiner

Date signed 5/28/47

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52129

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D G52129 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 841 Belgian ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) [illegible]
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 841 Belgian Ave (If rural, give location)
(e) Citizen of foreign country? Belgium (or No)
If yes, name country

3 (a) FULL NAME Lillie J. Houck

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Eugene
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20 1867

8. AGE: Years	Months	Days	If less than one day
80	2	7	hr. min.

9. Birthplace Frederick Co. Md. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Morton R. Handle
13. Birthplace Frederick Co. Md.

MOTHER
14. Maiden Name Mary Jane Watts
15. Birthplace Frederick Co. Md.

16 (a) Informant Walter E. Houck
(b) Address 841 Belgian ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 31-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Md.

18 (a) Funeral director John A. Nelson
(b) Address 4201 Greenmount Ave

MAY 28 1947 (Date received by Registrar) (Huntington-Williams, M.D.)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1947 at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 14 1943 to May 27 1947 and that I last saw h[illegible] alive on May 22 1947

I saw the cause of death Chronic Myocarditis — Duration 6 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide? No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. L. Gordy Howard M. D.
Address 516 Hartford Rd. Date signed 5/27/47

V S 150

G52130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

G52130 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or instt. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 205 N. Collington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes M. Pac.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edward A. Pac

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 13 - 1912

8. AGE: Years 35 | Months 3 | Days 13 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Harry L. Smith
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mamie L. Connolly
15. Birthplace Balto. Md.

16 (a) Informant Edward A. Pac
(b) Address 205 N. Collington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 30 47 (month) (day) (year)

(c) Cemetery or crematory Holy Cross
Location Hernwood Hall Rd.

18 (a) Funeral director John J. Hagan
(b) Address 800 E. Balto. St.

19 (a) (b) Registrar

28 1947
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/26 1947, at 1:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/23 1947 to 5/26 1947 and that I last saw her alive on 5/26 1947.

Immediate cause of death Cerebrosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sam Rosenbaum Jr. M. D.
Address Sinai Hospital Date signed 5/26/47

X

G52131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G52131

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3523 Brehms La.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3523 Brehms La.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Agnes Collins

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: William P. Collins
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Aug. 6, 1860

8. AGE: Years 86 | Months 9 | Days 20 | If less than one day: ###### hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name W. Philbin
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Bridget Faherity
15. Birthplace Ireland

16 (a) Informant Christopher W. Collins
(b) Address 3523 Brehms La.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/30/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Avenue

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) ..... (Date received by registrar) (b) ..... Registrar

MAY 28 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26th., 1947, at 10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1947 to May 26 1947
and that I last saw h[illegible] alive on 5-26 1947

Immediate cause of death	Duration
Chronic myocarditis	5 yrs.
Due to uremia	
Due to –	
Other Conditions –	

(Include pregnancy within 3 months of death)
Date of operation –
Major findings of operation –
of autopsy –

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide –
(b) Date of occurrence – at M
(c) Where did injury occur? – (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? – While at work? –
(Specify type of place)
(e) Means of injury

23. Signature J. Dana Mooney
Address 3165 Belair Rd Date signed 5-27-47
M. D.

X

G52132 — BALTIMORE CITY HEALTH DEPARTMENT — G52132 — Registered No. 24747

CERTIFICATE OF DEATH 15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2924 Round Road
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2924 Round Road (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Catherine Fowlkes

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 23, 1931

8. AGE: Years	Months	Days	If less than one day
15	7	264	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name John Fowlkes
13. Birthplace Nottaway Co. Va.

MOTHER
14. Maiden Name Gladys Threat
15. Birthplace Richmond Va.

16 (a) Informant Gladys F. Fowlkes
(b) Address 2924 Round Road

17 (a) (Burial, cremation, or removal) (b) Date thereof May 31 47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calary
Location Balto.
18 (a) Funeral director Walter B. Scruggs
(b) Address 139 Wildwood Blvd
19 (a) (b) Registrar

MAY 28 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1947, at 5:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 10 1947 to May 26 1947, and that I last saw her alive on May 26, 1947

Immediate cause of death Tuberculosis — Duration 3 yrs.
Due to —
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —
23. Signature R Bligh Slaton M. D.
Address 501 Cherry Hill Rd Date signed 5-27-47

X

1 G57133 — BALTIMORE CITY HEALTH DEPARTMENT — G57133 Registered No.

CERTIFICATE OF DEATH 83a

PLEASE WRITE PLAINLY. Every item of information should be carefully supplied. The use of INDELIBLE INK. BLACK LEAD PENCIL or RED INK. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edwards Saratoga Sts
(c) Hospital or institution: Mercy Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1558 Moreland Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Hiram J. Weiskopf (Hiram J. Weiskopf)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Ilka Weiskopf If alive, give age years
ILKA WEISKOPF

7. Birth date of deceased (mo., day, yr.) Oct. 29, 1885

8. AGE: Years	Months	Days	If less than one day hr.	min.
60	6	28		

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Attorney
11. Industry or business

FATHER 12. Name Joseph Weiskopf
13. Birthplace Germany

MOTHER 14. Maiden Name Minna Jacobs
15. Birthplace Germany

16 (a) Informant Mrs Ilka Weiskopf
(b) Address 1558 Moreland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 28 1947 (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew Cemetery
Location Belair Road

18 (a) Funeral director J. Ahrens & Co
(b) Address 2 Saratoga St

MAY 28 1947 (Date rec'd by registrar) (Registrar) Registered No.

Waiting for Attending Physician

FORMS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/27 1947, at 10:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/27 1947, to 5/27 1947, and that I last saw him alive on 5/27 1947.

Immediate cause of death: Pneumonia — Duration

Due to: Subarachnoid hemorrhage

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
(f) Signature August Keil
Address Mercy Hosp Date signed 5/27/47 M. D.

C52134 P. Barry

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. C52134

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 929 N. Gadeira
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltmor (If outside city or town limits, write RURAL and give town)
(d) Street No. 929 N. Gadeira (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alois Vlcek

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frances Vlcek

6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) June 23/74

8. AGE: Years 72 | Months 11 | Days 4 | If less than one day hr. min.

9. Birthplace Slovakia (Town, county, and state)

10. Usual Occupation Wood Turner

11. Industry or business Furniture

FATHER 12. Name Joseph Vlcek
13. Birthplace Slovakia

MOTHER 14. Maiden Name Rose Sarocen
15. Birthplace Belgium

16 (a) Informant Frances Vlcek
(b) Address 929 N. Gadeira St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 29/47 (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Baltimore Md

18 (a) Funeral director Ralph Brockton
(b) Address 900 N. Chester St

MAY 29 1947 (b) [illegible] for Williams, M.D.
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1947 at 3:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/3 1947 to 5/27 1947 and that I last saw him alive on 5/26 1947

	Duration
Immediate cause of death: Coronary Occlusion	1 day
Due to: myocardial arteriosclerosis	?
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Pakorny M.D.

Address 2201 E. Madison St Date signed 5/27/47

G52135

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

Registered No. G52135

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway.
(c) Hospital or institution: Church Home & Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days.
(e) Length of stay in Baltimore (yrs., mos., or days) Never.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Cockeysville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Old Texas Rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr William Long.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
52 ?			hr. min.

9. Birthplace Cockeysville Maryland
(Town, county, and state)

10. Usual Occupation Bartender

11. Industry or business Bartender

FATHER
12. Name Mr William Long
13. Birthplace Balto. Co., Md

MOTHER
14. Maiden Name Miss Ella Sanders
15. Birthplace Balto Co Md

16 (a) Informant John Long
(b) Address Texas, Md

17 (a) Burial (b) Date thereof May 30 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Reformed Lutheran
Location Jacksonville, Balto. Co., Md

18 (a) Funeral director Landon M. Bosley
(b) Address Texas Md.

19 (a) MAY 29 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 1947 at 10:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 24 1947 to May 28 1947 and that I last saw h[illegible] alive on May 27 1947.

	Duration
Immediate cause of death Edema pulmonary	24 hrs.
due to circulatory disturbance	
Due to Cardiac insufficiency.	6 mos.
Due to Arteriosclerotic heart disease	5 yrs
Other Conditions Arteriosclerosis general	5-4 yrs

(Include pregnancy within 3 months of death)

Date of operation None.

Major findings of operation:

of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Buchanan M. D.
Address Church Home & Hosp. Date signed 5/28/19

VS 150

G52136

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1612

Registered No. G52136

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Owings Mills
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul D. REDIFER

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22-47

8. AGE: Years	Months	Days	If less than one day
		6	hr. min.

9. Birthplace Balto Co. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Roy Redifer
13. Birthplace Va.

MOTHER
14. Maiden Name Margaret May Sprinkel
15. Birthplace Carroll Co

16 (a) Informant Roy Redifer
(b) Address Owings Mills

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 29-47 (month) (day) (year)
(c) Cemetery or crematory Reisterstown Methodist
Location Balto Co

18 (a) Funeral director J. F. Kline's Sons
(b) Address Reisterstown

MAY 29 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 1947, at 12:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-26-1947 to 5-28-1947 and that I last saw him alive on 5-28 1947

Immediate cause of death	Duration
Resp. failure	
Due to Pulmonary edema — terminal	
Due to Uremia + post. urethrean hemorrhage	
Other Conditions Paralytic ileus etc. to infected umbilicus	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles H. Hawkins M.D.
Address Univ. Hosp. Date signed 5-28-47

G52137

515384.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

102

G52137

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. Y. (b) County
(c) City or town New York (If outside city or town limits, write RURAL and give town)
(d) Street No. 350 E. 52nd St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Adolph W. Lederer. ADOLPH WALTER LEDERER

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: ?

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Martha Blum Lederer

6 (c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.) 10-4-89

8. AGE: Years	Months	Days	If less than one day
57 5[illegible]	7	24	hr. min.

9. Birthplace: Phila, Pa. (Town, county, and state)

10. Usual Occupation: Tobacco Business

11. Industry or business: Retired

FATHER
12. Name: Jacob Lederer
13. Birthplace: Germany.

MOTHER
14. Maiden Name: Sophia Jordan
15. Birthplace: Germany.

16 (a) Informant: Record
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 5/29/47 (month) (day) (year)
(c) Cemetery at [illegible]
Location: Memphis, Tenn.

18 (a) Funeral director: WM. J. TICKNER & SONS INC.
(b) Address: North & Pa. Aves. Balto. 17, Md.

19 MAY 29 1947 (Date received by Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

A

20. DATE OF DEATH May 28 1947, at 3.55 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1947, to May 28 1947, and that I last saw him alive on May 28 1947.

Immediate cause of death	Duration
Malignant Hypertension	2 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Maurice B. Visscher M. D.

Address: J H H Date signed 28 May 47

G52138

515745

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

156 B

Registered No. G52138

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Sunbury W. Va.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: MARY M. PAYNE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Wm. A. John A. Payne

6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) 5-9-07

8. AGE: Years 40 | Months - | Days 20 | If less than one day ... hr. ... min.

9. Birthplace W. Va. (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Walter L. Mundy
13. Birthplace W. Va.

MOTHER
14. Maiden Name Katherine Malloy
15. Birthplace W. Va.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof May 29 1947 (month) (day) (year)
(c) Cemetery or crematory Suffolk
Location Suffolk, Va.

18 (a) Funeral director Wm. Cook Jr.
(b) Address 217 E. Paul St.

MAY 29 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1947, at 1 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/21 1947 to 5/29 1947, and that I last saw him alive on 5/29 1947.

Immediate cause of death	Duration
(a) Myasthenia Gravis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John H. Garrett III
Address Johns Hopkins Hosp. Date signed 5/31/47

VS 150

652139

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

467

Registered No. 652139

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 12 days
(e) Length of stay in Baltimore (yrs., mos., or days): 12 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Ohio (b) County:
(c) City or town: Conneaut
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 384 Main St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: Edward Joseph Gordon

3 (b) If veteran, name war:

3 (c) Social Security Account No.: 366-14-9766

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife:
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 17, 1884

8. AGE: Years	Months	Days	If less than one day
62	10	10	hs. min.

9. Birthplace: Ontario, Canada
(Town, county, and state)

10. Usual Occupation: Pilot

11. Industry or business: Seafarer

FATHER
12. Name: James Gordon
13. Birthplace: Canada

MOTHER
14. Maiden Name: Elizabeth Conlin
15. Birthplace: Canada

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial
(Burial, cremation, or removal) (b) Date thereof: 5/29/47 (month) (day) (year)
(c) Cemetery or crematory: St Michaels
Location: Cobourg, Ontario, Canada

18 (a) Funeral director: Walton & Pool
(b) Address: 1360 Penn Ave

19 (Date rec'd by registrar) MAY 29 1947 Hampton Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 27 1947, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1947 to May 27 1947 and that I last saw him alive on May 27 1947

Immediate cause of death: Postoperative State, Colostomy — Duration: 5 Days

Due to: Carcinoma of rectum with liver metastases — Duration: unk.

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operations:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Wm. Monroe, M.D.
Address: U.S. Marine Hosp. Date signed: 5-28-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52140 G52140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1176

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4638 York Road.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4638 York Road. (If rural give location)
(e) Citizen of foreign country (Yes or No) If yes, name country

3 (a) FULL NAME Francis T.R. Kennedy.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Cecelia M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 16 1897

8. AGE: Years 49 | Months 6 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Martin Kennedy
13. Birthplace Balto. Co. Md.

MOTHER 14. Maiden Name Mary Kenny
15. Birthplace Balto. Co. Md.

16 (a) Informant Cecelia M. Kennedy
(b) Address 4638 York Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 30-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director John A. McCan
(b) Address 4701 Greenmount ave

19 MAY 29 1947 (Date received by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27th 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from MAY 14 1947, to MAY 27 1947, and that I last saw him alive on MAY 27 1947.

	Duration
Immediate cause of death MYOCARDIAL INFARCTION DUE TO CORONARY	ACUTE
Due to THROMBOSIS	3 DAYS
ASSOCIATED WITH	
Due to ANGINA PECTORIS	18 MOS
Other Conditions DUODENAL ULCER	10 YRS

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ralph G. Hills M. D.
Address 18 E Eager st Date signed May 28 '47

VS 150

94a

65211

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 94a

Registered No. 65211

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution:
Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 400 Dulton Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mr Thomas Herbert Murray.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mrs Thomas Edna Murray
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) March 3 1887

8. AGE: Years	Months	Days	If less than one day
60	2	25	....hr. ....min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Clerk
11. Industry or business B+O R.R.

FATHER
12. Name Emory Wilson Murray
13. Birthplace Maryland

MOTHER
14. Maiden Name Anna Leister
15. Birthplace Maryland

16 (a) Informant Mrs Frances Edna Murray.
(b) Address 400 Dulton Ave Catonsville

17 (a) Burial (b) Date thereof May 31 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Leary Smith & Co
(b) Address 623 N Howard St

19 (a) MAY 29 1947 Washington Hollow, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 1947, at 5:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 26 1947 to May 28 1947 and that I last saw h[illegible] alive on May 28 1947.

Immediate cause of death	Duration
Asphyxia by mycocardium due to embolism	48 hrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Bachanach M. D.
Address Church Home & Hosp. Date signed 5/28/47.

X

G52142

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G52142

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 755 W. Fayette St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 755 W. Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John A. Johansen

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 23, 1896

8. AGE: Years	Months	Days	If less than one day
50	7	5	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Retired A & P. Co

FATHER
12. Name Samuel Johansen
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie M. Jentzen
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs Mary M. Johansen
(b) Address 373 No. Dukeland Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/31/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem
Location Pikesville Md.

18 (a) Funeral director John J. Cowan & Son
(b) Address 901-03 N. Collins St

MAY 29 1947 Huntington Williams M.D.
(Registrar) (Signature of Health Officer)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28th 1947, at 10.01 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 26 1947 to May 28 1947 and that I last saw h.i.m. alive on May 28 1947

Immediate cause of death	Duration
Myocardial Infarction	
Due to Coronary Thrombosis	
Due to arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature K. Kaufelt
Address 2116 W. Pratt St. Date signed 5/31/47

VS 150

G52143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G52143 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1718 Kenston ave
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1718 Kenston Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Glase

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Ida

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years 74 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Yale
13. Birthplace Russia

MOTHER
14. Maiden Name Edith
15. Birthplace Russia

16 (a) Informant Ida Glase
(b) Address 1718 Kenston ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-29-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1496 Balto St

19 (a) (Signature of local registrar) (b) Huntington Williams M.D. Registrar

MAY 29 1947
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-28- 1947; at 7:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 0 1947 to 5/28 1947, and that I last saw him alive on 5/25 1947.

Immediate cause of death	Duration
Coronary thrombosis (myocardial disease)	
Due to Hypertension arteriosclerosis	
Due to CV disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H B Kemp M. D.
Address 231 N. Mt Ave Date signed 5/29/47

X

52141

BALTIMORE CITY HEALTH DEPARTMENT

AB-110868 BC# D19480 CERTIFICATE OF DEATH 160a

Registered No. D-52141

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 22-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 650 Haw Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23-1947

8. AGE: Years | Months | Days 1 | If less than one day ....hr. ....min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jewel Jones
13. Birthplace Va.

MOTHER
14. Maiden Name Lucille Staton
15. Birthplace Va.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 5-27-47 (month) (day) (year)
(c) Cemetery or crematory Baltimore City Hospitals
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 MAY 29 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1947, at 11.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-23- 1947 to 5-24- 1947, and that I last saw him alive on 5-24- 1947

Immediate cause of death Intracranial Hemorrhage — Duration

Due to Breech Delivery

Due to

Other Conditions Breech Delivery

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin H. Sachs M.D.
Address Balto City Hosp Date signed 5/28/47

V S 150

G52145

BALTIMORE CITY HEALTH DEPARTMENT ✓ G52145 Registered No.

CERTIFICATE OF DEATH 157a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1345 N. Gilmor St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1345 N. Gilmor St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jasper Willoughby

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/11/1938

8. AGE: Years	Months	Days	If less than one day
8	8	16	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Student
11. Industry or business

FATHER
12. Name Jasper Willoughby, Sr
13. Birthplace N. C.

MOTHER
14. Maiden Name Weller, Lynch
15. Birthplace N. C.

16 (a) Informant Jasper Willoughby Jr
(b) Address 1345 Gilmor St

17 (a) 5/29/42 (Buried, cremation or removal) (b) Date thereof Burial (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Greenmount, Md.

18 (a) Funeral director Geo. E. Nelson
(b) Address 1303 Pennsylvania Ave.

19 (a) May 29 1942 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1942, at 8:30 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hydrocephalus, internal
chronic
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Ryan M.D.
Medical Examiner
Date signed 5-28-42

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 181

G52146

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V61

G52146 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2400 Keyworth Ave
(c) Hospital or institution: 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town) 2400 Keyworth Ave
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel W Wolpoff

3 (b) If veteran, name war

3 (c) Social Security Account No. 577-03-9648

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Annie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years 57 | Months | Days | If less than one day hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: Maerchant

11. Industry or business

MOTHER / FATHER

12. Name: Abraham Wolpoff

13. Birthplace: Russia

14. Maiden Name: Annie ?

15. Birthplace: Russia

16 (a) Informant: Mrs Annie Wolpoff

(b) Address: 2400 Keyworth Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 30, 1947 (month) (day) (year)

(c) Cemetery or crematory: Sharrei Zion Cong.

Location: Hamilton Ave Rosedale

18 (a) Funeral director: Sol Levinson & Bros

(b) Address: 1124-1126 W North Ave

19 (a) Date received by registrar: May 29 1947 (b) Registrar: [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 28 1947 at 1113aM

21. I certify that death occurred on the date above stated; that I attended deceased from MAY 1946 to MAY 28 1947 and that I last saw h(IM) alive on MAY 28 1947.

Immediate cause of death	Duration
Respiratory Failure	
Due to Arteriosclerotic Cardiovascular renal disease	
Due to	
Other Conditions Diabetis mellitus	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: I. Shorofsky M.D.

Address 601 N. Monroe St Date signed 5/28/47

§ 1310

G52147

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164a

Registered No. G52147

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mths.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Falls Church (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES Mc GRAW

3 (b) If veteran, name war: World I
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Racine Dodson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29, 1898

8. AGE: Years	Months	Days	If less than one day
48	10	0	hr. min.

9. Birthplace Cortlandt, N.Y. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name George W. McGraw
13. Birthplace N.Y.

MOTHER
14. Maiden Name Julia M. Bush
15. Birthplace N.Y.

16 (a) Informant Dr. Robert McGraw
(b) Address 2 E. 85th St. N.Y.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof May 29, 1947 (month) (day) (year)
(c) Cemetery or crematory Newtown
Location Conn.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves.

19 (a) MAY 29 1947 (b) [illegible] Huntington Williams, M.D.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1947 at 6:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death is in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation by hanging

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-29-47 at 5:15 P.M.
(b) Where did injury occur? Johns Hopkins Hosp.
(c) Did injury occur at home, on farm, industrial place, in public place? Hospital While at work? no
(d) Means of injury Hanged self in [illegible]

23. Signature George W. McGraw M.D. (Medical Examiner)
Date signed 5/29/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

52118

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. 52118

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1418 Harlem Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1418 Harlem Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Ashby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife William Ashby
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years	Months	Days	If less than one day
45			hr. min.

9. Birthplace Amherst, Va. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name William Franklin
13. Birthplace Amherst, Va.

MOTHER
14. Maiden Name Lucy Rose
15. Birthplace Amherst, Va.

16 (a) Informant Mary Moore
(b) Address 1418 Harlem Ave

17 (a) B (Burial, cremation, or removal) (b) Date thereof 6-2-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A.A. Co.

18 (a) Funeral director Samuel W. Sullivan Jr
(b) Address 1011 N. Arlington Ave

MAY 29 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1947, at 2 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Edema
Due to Acute Pneumonia
Heart Failure

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Edw. A. Rogers M.D. Medical Examiner.
Date signed 5-29-47

C52149

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. C52149

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline St.
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 13
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1628 N. Montford Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles A. Wheeley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced:

6 (b) Name of husband or wife Lillie B. Wheeley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 1st 1871

8. AGE: Years 75 | Months 6 | Days 26 | If less than one day hr. min.

9. Birthplace Richmon Va
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Thomas Wheeley
13. Birthplace Va

MOTHER 14. Maiden Name Ellen Owens
15. Birthplace Va

16 (a) Informant Mrs L. Wheeley
(b) Address 1628 N. Montford Ave

17 (a) Burial (b) Date thereof 5-31st 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore
Location E Northy Ave Ext

18 (a) Funeral director Leo G. Gooch
(b) Address 1901-03 N. Patterson Park Ave

19 (a) (b)
(Signature and address of funeral director)

MAY 29 1947 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/27/47 19 at 11:55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/24 19 to 5/27 1947 and that I last saw h[illegible] alive on 5/27 1947.

Immediate cause of death: Cardiorespiratory Collapse — Duration

Due to: Spontaneous Pneumothorax

Due to:

Other Conditions Cardiac failure with Generalized Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard H. Young M.D.
Address St Josephs Hosp Date signed 5/27/47

VS 150

114E

G52150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 H

Registered No. G52150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland Gen'l Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 523 E 38th St
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ELLA BLANCHE DAVIS

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-12-73

8. AGE: Years	Months	Days	If less than one day
73	6	16	hr. min.

9. Birthplace Baltimore, MD.
(Town, county, and state)
10. Usual Occupation
11. Industry or business —

FATHER
12. Name JOHN ARNOLD
13. Birthplace Fredrick MD.

MOTHER
14. Maiden Name ARABELLA McCULLAEY
15. Birthplace Baltimore County

16 (a) Informant daughter
(b) Address 523 E 38th ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 31-47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. North. ave

18 (a) Funeral director John A. Moran
(b) Address 1 E Saratoga St Baltimore, Md

19 MAY 29 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-28 1947 at 11:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-15 1947 to 5-28 1947 and that I last saw her alive on 5-28 1947

Immediate cause of death: Respiratory Failure — Duration
Due to: Generalized Peritoneal Carcinomatosis
Due to —
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 5-13-47
Major findings of operation: Gen'l Carcinomatosis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Geo. Maxwell M.D.
Address Md Gen'l Hosp. Date signed 5-28-47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

57151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

Registered No. 57151

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor Ave. & Dukeland St.
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3100 Remington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jesse Climenson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Maude Climenson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 4, 1883

8. AGE: Years	Months	Days	If less than one day
63	5	24	hr. min.

9. Birthplace Pennsylvania (town, county, and state)
10. Usual Occupation Bricklayer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Maude Climenson
(b) Address 3100 Remington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 31/47 (month) (day) (year)
(c) Cemetery or crematory Mouland Park
Location Taylor Ave

18 (a) Funeral director Chenowith & Sonman
(b) Address 2615-17 Chestnut Ave.

19 (a) MAY 29 1947 Huntington Williams M.D. Registrar
(Registered by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28, 1947, at 8 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 24, 1947 to May 28, 1947 and that I last saw him alive on May 28, 1947.

Immediate cause of death	Duration
Cardio-respiratory failure.	
Due to Pulmonary edema.	
Due to Cerebro-vascular accident	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leon Toby M.D.
Address West Balto. Gen. Date signed 5/28/47

Hosp.

G52152 G52152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 920

Registered No. G52152

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 206 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 329 Bassitar Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Gwynn Hudgins

3 (b) If veteran, name war —
3 (c) Social Security Account No. 215-18-2309

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bessie Wynne Hudgins
6 (c) If alive, give age (56) years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1886

8. AGE: Years 60 | Months 5 | Days 4 | If less than one day: hr. min.

9. Birthplace: Gwynn, Va.
(Town, county, and state)
10. Usual Occupation: Master
11. Industry or business: Seafarer

FATHER
12. Name: Robert Hudgins
13. Birthplace: Mathews, Va.

MOTHER
14. Maiden Name: Martha (Name) Louisa Edwards
15. Birthplace: Mathews, Va.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) BURIAL (b) Date thereof 5 30 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory: ST. JOHNS
Location: HAMPTON VA.

18 (a) Funeral director: A.R. SLADE
(b) Address: 4907 YORK RD.

19 (a) MAY 29 1947 Huntington Williams, M.D.
(Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 1947, at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 3 1946, to May 28 1947, and that I last saw him alive on May 28 1947.

	Duration
Immediate cause of death: Cardiac Decompensation	
Due to: hiatal + ant. valve insufficiency	
Due to: bacterial endocarditis	
Other Conditions: Splenic infarcts suppurative	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
Findings of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Wm. Monroe M. D.
Address: U.S. Marine Hosp. Date signed 5-28

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

652153 McNeill ✓ BALTIMORE CITY HEALTH DEPARTMENT Registered No. 652153

CERTIFICATE OF DEATH 83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hosp. 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1526 Division (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William McNeill
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	N	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years	Months	Days	If less than one day
43			hr. min.

9. Birthplace Dunn N.C. (Town, county, and state)
10. Usual Occupation Barber
11. Industry or business

FATHER
12. Name Isaac McNeill
13. Birthplace Dunn N.C.

MOTHER
14. Maiden Name Lina Walker
15. Birthplace Dunn N.C.

16 (a) Informant Owen Neill
(b) Address 1326 Division St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 29, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cem. Location Brooklyn Md

18 (a) Funeral director Elroy D. Gibson
(b) Address 607 N Bloadway ave

19 (a) MAY 29 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/26 1947 at 9 05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/14 1947 to 5/26 1947 and that I last saw h[illegible] alive on 5/26 1947

Immediate cause of death Subarachnoid Hemorrhage — Duration 3 hrs
Due to Hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Preston Grant
Address 1514 Division St Date signed 5/27/47 M.D.

VS 180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

652154

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 652154

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2719 E. Monument St.
(c) Hospital or institution: 7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2719 E. Monument St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME HATTIE MARIE BAKER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Frank Baker, Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 7, 1896

8. AGE: Years	Months	Days	If less than one day
50	6	20	hr. min.

9. Birthplace Baltimcre, Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Vincent Jelinek
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Frank Baker, Sr.
(b) Address 2719 E. Monument St.

17 (a) Burial (b) Date thereof 5/30/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Horner's Lane, Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

MAY 29 1947 (of Huntington for Williams, Mgr
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1947, at 8:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1945 to May 27 1947.
and that I last saw h[illegible] alive on May 27 1947.

	Duration
Immediate cause of death Coronary Thrombosis	5/27/47
Due to Chr. Myocarditis	5/1/45
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William L. Rosario M. D.
Address 501 a Reservoir St. Date signed 5/29/47

VS 150

G52155

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G52155 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4718 Kernwood Ave
(c) Hospital or institution:
Annacosta Nursing Home ?
(d) Length of stay in hospital or inst. (yrs., mos., or days) Unknown
(e) Length of stay in Baltimore (yrs., mos., or days) 79 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4718 Kernwood Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Alice Carter Biscoe

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband: Edwin Eugene Biscoe

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 27, 1867

8. AGE: Years 79 | Months 7 | Days 2 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Desmond John Carter
13. Birthplace Maryland

MOTHER
14. Maiden Name Cecelia Royston
15. Birthplace Maryland

16 (a) Informant Mrs. Ruth Bishop
(b) Address 4718 Kernwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/31/47 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (Date received by registrar) MAY 29 1947 Registrar Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29, 1947, at 5:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10 1935 to May 29 1947, and that I last saw her alive on May 13 1947.

Immediate cause of death: Pulmonary Edema — Duration:

Due to: Chronic Myocarditis — 12 yrs

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Major findings:
Of operations:

Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. T. Cole M. D.
Address 6014 York Road Date signed

VS 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52156

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G52156 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1600 N. Milton Ave.
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1600 N. Milton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gaetano Scavuzzo

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 215-01-8782

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Angelina Scavuzzo
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16, 1883

8. AGE: Years	Months	Days	If less than one day
64	1	11	hr. min.

9. Birthplace: Italy
(Town, county, and state)

10. Usual Occupation: Clothing

11. Industry or business: Schloss Bros.

FATHER
12. Name: Joseph Scavuzzo
13. Birthplace: Italy

MOTHER
14. Maiden Name: Silvaatri
15. Birthplace: Italy

16 (a) Informant: Mr. Joseph Scavuzzo
(b) Address: 1600 N. Milton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/31/47 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Baltimore, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: North & Penna. Aves. Baltimore

19 MAY 29 1947 (b) Registered by [illegible] Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1947, at 7:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-24- 1947, to 5-27- 1947 and that I last saw him alive on 5-27- 1947

Immediate cause of death	Duration
Cerebral hemorrhage	4 days
Due to Cardio-Vascular-renal disease	9 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Milton C. Levey M. D.
Address 2117 Belair Rd Date signed 5-29-47

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G58157 — 83a — G58157 — Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3108 Wylie Ave.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3108 Wylie Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Harry I. Yake

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Effa K. Yake

6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Oct. 2, 1874

8. AGE: Years 72 | Months 7 | Days 26 | If less than one day ... hr. ... min.

9. Birthplace Penna.
(Town, county, and state)

10. Usual Occupation Watchman,

11. Industry or business Marine Guard,

FATHER
12. Name John Yake,
13. Birthplace Penna.

MOTHER
14. Maiden Name Annie Alwyne,
15. Birthplace Penna.

16 (a) Informant Mrs. Effa K. Yake,
(b) Address 3108 Wylie Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 5/31/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director Le Vernon Lemmon.
(b) Address 4611 Park Heights Ave.

19 (a) 1947 [illegible] by registrar Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28, 1947 19 , at 7.30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/27 1947 to 5/28 1947
and that I last saw h im alive on 5/28 1947

Immediate cause of death: Apoplexy

Due to: Cerebral Arteriosclerosis & hypertension

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration: Not known

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis L. Blum, M. D.
M. D.
Address 2310 Eutaw Place, Date signed

V S 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G52158

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G52158

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene St
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3212 Batavia Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Augustus Webster Cooper
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Leah M.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1882
8. AGE: Years 65 Months Days If less than one day hr. min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Sales & Building
11. Industry or business Loan

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. Webster Cooper
(b) Address 3529 Gelston Drive
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-31-47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto
18 (a) Funeral director Leopold J. Guck
(b) Address 5305 Harford Road
19 (a) MAY 29 1947 (Date received by registrar) Huntington Williams, M.D. Address University Hospital

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28, 1947, at 2:25 p M
21. I certify that death occurred on the date above stated; that I attended deceased from April 4, 1947 to May 28, 1947 and that I last saw h[illegible] alive on May 28, 1947.

Immediate cause of death	Duration
Carcinoma of the Liver	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation May 19, 1947
Major findings of operation: Nodules Metastasis retro peritoneal
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. Eng
Address University Hospital Date signed 5-29-47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

052159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

181

052159 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Lombard Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 4300 Valley View Rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Maude

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 31-1867

8. AGE: Years	Months	Days	If less than one day
79	8	29	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name George Thompson
13. Birthplace Eng.

MOTHER 14. Maiden Name Sarah
15. Birthplace

16 (a) Informant Dorothy Thompson
(b) Address 4300 Valley View

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/2/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto

18 (a) Funeral director Leonard J. Ruck
(b) Address 530 E Hoffman St.

19 MAY 29 1947 Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-29 1947 at 6:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-3 1947 to 5-29 1947, and that I last saw h. alive on 5-26 1947.

Immediate cause of death	Nephritis	Duration
Due to	2nd & 3rd degree Burns.	
Due to		
Other Conditions	Arteriosclerosis Senility	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 5/3/47 at ? M
(c) Where did injury occur? Res. - Valley View Balto Co
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Means of injury Mattress caught fire - while smoking

23. Signature J. Blackstone M.D.
Address Univ. Hosp. Date signed 5-29-47

VS 150

For H.D.C. Hofferth by Howard J. Malone, M.D.

65160

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 65160

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D-OR
(c) Hospital or institution: University Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1810 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter C. Byrd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11, 1879

8. AGE: Years	Months	Days	If less than one day
67	10	17	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation State Tax Dept.

11. Industry or business

FATHER
12. Name James E. Byrd
13. Birthplace Va.

MOTHER
14. Maiden Name Catherine Fletcher
15. Birthplace Balto.

16 (a) Informant Evelyn M. Byrd
(b) Address 3700 Greenmount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/30/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemy.
Location Woodlawn, Md.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1940 Eutaw Place

MAY 29 1947 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/28 1947 at 6:05 P.M.

21. I certify that I took charge of the remains described above, held an Inquisition thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio-Vascular Disease

Due to

Other Conditions Chronic Alcoholism

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. P. Mitchell M.D.
Medical Examiner.
Date signed 5/28/47

VS 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52161

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G52161 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1436 William St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town.)
(d) Street No. 1436 William St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Lilly M. Chaney

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3 - 1881

8. AGE: Years 65 | Months 6 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business Housewife

FATHER 12. Name William N. Fleming

13. Birthplace Frederick Co. Md.

MOTHER 14. Maiden Name Annie Wolf

15. Birthplace Frederick Co. Md.

16 (a) Informant M. Irwin Chaney

(b) Address 1436 William St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-31-1947 (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location [illegible] Md. G.A. Co. Md.

18 (a) Funeral director Flynn & Fleming

(b) Address 1426 Light St.

19 (a) Date received MAY 29 1947 (b) Registrar [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/28/47 19 47, at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 4, 1942 to May 28 19 47, and that I last saw alive on May 28, 1947.

Immediate cause of death Coronary Occlusion

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. P. Fraim M.D.

Address 1319 Lafayette Date signed 5/29/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

052162

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 052162

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1730 Byrd St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1730 Byrd St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Herbert F. Reimer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6-(a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 9, 1898

8. AGE: Years 48 | Months 6 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Elevator Dispatcher

11. Industry or business Court Square Bldg

FATHER 12. Name Frank Reimer

FATHER 13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Virginia Rider

MOTHER 15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Margaret E. Reimer

(b) Address 1730 Byrd St.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 5-31-1947 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore, Md.

18 (a) Funeral director Flynn & Flannery

(b) Address 1426 Light St.

19 (Filed date by registrar) MAY 29 1947 Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28th 1947, at 5:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary thrombosis
Pulmonary edema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 5/28/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C52163 BCH #79673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

Registered No. C52163

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.C.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1225- N. Eden Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BABY CROWELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-29-47

8. AGE: Years | Months | Days | If less than one day hr. 5 min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Bud Crowell
13. Birthplace N.C

MOTHER 14. Maiden Name Louise Watson
15. Birthplace NC

16 (a) Informant Bud Crowell
(b) Address 1225 N Eden St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-29-47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location B. A. Co.

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) MAY 29 1947 (Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29, 1947, at 5.45a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Atelectasis of lungs

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 5-29-47

VS 151

G52164 X ✓ G52164

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 Caroline St
(c) Hospital or institution St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Dundalk (22) (If outside city or town limits, write RURAL and give town)
(d) Street No. 7322 Manchester Rd. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No) If yes, name country Italy (Naturalized U.S. 40 yrs)

3 (a) FULL NAME Mrs. Rose Trotta

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Angelo Trotta

6 (c) If above, give age years

7. Birth date of deceased (mo., day, yr.) 11 / / 88.

8. AGE: Years 58 | Months 6 | Days | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name Gregory Camuzzard

13. Birthplace Italy

MOTHER

14. Maiden Name Josephine Guglielmetti

15. Birthplace Italy

16 (a) Informant Angelo Trotta

(b) Address 7322 Manchester Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 (Month) 00 (day) 1947 (year)

(c) Cemetery or crematory Oak Lawn Cemetery

Location Eastern ave & Rossville Blvd

18 (a) Funeral director Bendell & Sipple

(b) Address 312 S. Highland ave

MAY 29 1947 Registrar for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1947, at 9.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 20 1947 to May 27 1947, and that I last saw her alive on May 27 1947.

Immediate cause of death	Duration
Cardiac Refractory failure	
Due to Tuberculosis due to Carcinoma, generalized	
Due to with Diabetes Mellitus	over
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edmund J. Owen

Address St. Joseph's H Date signed 5/21/47

VS 150

X

G52165 ✓ G52165

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital of Balt.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2024 Christian St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vanette, Boxer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Sam Boxer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 76 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business House Work

FATHER
12. Name
13. Birthplace Russia

MOTHER
14. Maiden Name Fannie Stocksky
15. Birthplace Russia

16 (a) Informant Mrs Rose Mallinowoff
(b) Address 2024 Christian Ave

17 (a) Burial (b) Date thereof May 30, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run Cem
Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) MAY 29 1947 (b)
(Date rec'd by registrar) Registrar

Washington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1947, at 1150 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/23 1947 to 5/29 1947 and that I last saw her alive on 5/29/47 19

Immediate cause of death: Cardiac Failure — Duration

Due to: Atherosclerotic Heart Disease

Due to:

Other Conditions: Generalized Carcinomatosis

(Include pregnancy within 3 months of death)

Date of operation 5/23/47

Major findings of operation: Generalized Carcinomatosis

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ernest Fisher M. D.

Address Sinai Hospital Date signed May 29 1947

X

G52166

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61 G52166

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1807 N. Bentalow St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 No Bentalow St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Sugar

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Max

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Bernard
13. Birthplace Austria

MOTHER
14. Maiden Name Fannie
15. Birthplace Austria

16 (a) Informant Max Sugar
(b) Address 1807 No Bentalow St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-30-47 (month) (day) (year)

(c) Cemetery or crematory
Location Hebrew Mt Carmel

18 (a) Funeral director Jack Lewis Inc
(b) Address 429 E Balto St

19 (a) Filed by registrar Huddleston Williams M... registrar

MAY 29 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-29-1947, at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-28-1947 to 5-29-1947; and that I last saw her alive on 5-29-1947.

Immediate cause of death
1) Coronary Thrombosis — Duration 15 minutes
Due to
Due to
Other Conditions Diabetes — 5 yrs.
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Earl L. Thornton M.D.
Address 4108 Liberty Hts Date signed 5/29/47

94a

G52167 BC#P79686 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 160a G52167 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St. Paul + 33rd. Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Box 169 A, Fisher Rd. (22) (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Dennis Taylor

3 (b) If veteran, name war: X
3 (c) Social Security Account No: X

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife: X
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) May 26, 1947

8. AGE: Years | Months | Days: 2 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation: X
11. Industry or business: X

MOTHER & FATHER
12. Name Eugene Vincent Taylor
13. Birthplace Newark, Ohio
14. Maiden Name Dorothy Tarbox
15. Birthplace Boston, Mass.

16 (a) Informant Mother
(b) Address Box 169 A, Fisher Rd Rt. 3 Balt. 22

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 30, 1947 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Memorial
Location Glen Burnie

18 (a) Funeral director John A. Greblunaskas Jr
(b) Address 423 S. Paca St.

19 (a) MAY 29 1947 (Date received by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 1947, at 1:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from MAY 27 1947 to MAY 28 1947, and that I last saw him alive on MAY 28 1947.

	Duration
Immediate cause of death: Respiratory failure	
Due to: Erythroblastosis fetalis	2 days
Due to:	
Other Conditions: Toxemia of pregnancy (Include pregnancy within two weeks of death)	2 days

Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold V. Cooper M.D. M. D.
Address Union Memorial Hospital Date signed 28 May 1947

~~F~~ C52168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. C52168

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Johns Hopkins Hospital
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 35 N Patterson Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sara Matz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Harry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years 53 | Months | Days | If less than one day hr. min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual Occupation
11. Industry or business: House Work

FATHER
12. Name: Jacob Siegel
13. Birthplace: Russia

MOTHER
14. Maiden Name: Jennie Siegel
15. Birthplace: Russia

16 (a) Informant: Harry Matz
(b) Address: 35 N Patterson Park Ave

17 (a) Burial (b) Date thereof May 30, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory: Hebrew Rosedale Cem
Location: Hamilton Ave

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-1126 W North Ave

19 MAY 30 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/29/47 1947, at 9 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 42 1947, to 5/29/47 1947, and that I last saw h[illegible] alive on 5/29/47 1947.

	Duration
Immediate cause of death: acute dilation of heart	one day
Due to: Chronic myocarditis myocardial insufficiency	two years
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 10 a E. Madison Date signed 5/30/47 M. D.

VS 150

G52169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51 C

Registered No. G52169

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4604 Roland Ave.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4604 Roland Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** James Brevard Derrickson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Margaret E. Miller
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) October 10, 1884

8. AGE: Years	Months	Days	If less than one day
62	7	19	hr. min.

9. Birthplace Berlin, Md.
(Town, county, and state)
10. Usual Occupation Druggist
11. Industry or business

FATHER
12. Name Dr. Edwin J. Derrickson
13. Birthplace Berlin, Md.

MOTHER
14. Maiden Name Harriett Louise William
15. Birthplace Berlin, Md.

16 (a) Informant Mrs. Margaret E. Derrickson
(b) Address 4604 Roland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/1/47 (month) (day) (year)
(c) Cemetery or crematory St. Paul's Churchyard
Location Berlin, Md.

18 (a) Funeral director John C. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

MAY 30 1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1947, at 10.40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 4 to 5 29 19 47 and that I last saw h[illegible] alive on 5 28 19 47

Immediate cause of death (a) Carcinoma of prostate — Duration
with generalized metastasis
Due to (b) Uremia, Acute
Due to (c)
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edwin Kravitz, M. D.
Address 1422 Park Ave. Date signed 5/30/47

VS 150

G52170

(5) BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G52170 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use no abbreviations. Do not write "do" for ditto marks. Be sure that correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 195 W. Mulberry St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 195 W. Mulberry St.
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Charlotte Stout

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife George W. Stout
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14, 1879

8. AGE: Years	Months	Days	If less than one day
68	1	14	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Charles Loring King
13. Birthplace Md.

MOTHER 14. Maiden Name Winifred Cloonan
15. Birthplace Md.

16 (a) Informant Milford B. Smith
(b) Address 195 W. Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-31-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director George A. Fearley
(b) Address 1701 Eutaw Ave + Lafayette St.
MAY 30 1947 (Huntington Williams, Mgr.)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/28 1947 at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/20 1947 to 5/28 1947 and that I last saw h[illegible] alive on 5/28/1947.

	Duration
Immediate cause of death Myocardial Degeneration	2 hrs.
Due to Hypertension, Essential	10 yrs.
Due to Arteriosclerosis	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Samuel E. Boyd
Address 1905 W. Balto Date signed 5/29/47

VS 150

G52171

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G52171

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 808 Evesham Ave
(c) Hospital or institution: # #
(d) Length of stay in hospital or inst. (yrs., mos., or days) #
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 808 Evesham Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country #

3 (a) FULL NAME Lillian A. Taylor

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: James F. Taylor
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Mar 21 1893

8. AGE: Years	Months	Days	If less than one day
54	2	15	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name # #
13. Birthplace # #

MOTHER
14. Maiden Name # #
15. Birthplace # #

16 (a) Informant James F. Taylor
(b) Address 808 Evesham Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-30-47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Rd

18 (a) Funeral director Chas. F. Evans & Son
(b) Address 118 W Mt Royal Ave

19 (a) MAY 30 1947 (Date rec'd by registrar) (b) Contingent on Williams MC

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 May 1947 at 7A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1947 to May 1947 and that I last saw h. alive on 25 May 47

Immediate cause of death	Duration
Cerebral Hemorrhage	1 Hour
Due to Hypertensive Cardio-Vascular Renal Disease	15 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. H. Kammer Jr.
Address 501 Sheridan Ave. Date signed 30 May 47

VS 150

G52172

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Register No. G52172

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3344 Virginia Ave.,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore,
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3344 Virginia Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth M. Martin.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife John J. Martin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 18, 1871

8. AGE: Years	Months	Days	If less than one day
76	3	11	hr. min.

9. Birthplace Ireland
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business at home

FATHER
12. Name Thomas Byrnes,
13. Birthplace England,

MOTHER
14. Maiden Name Mary Trout,
15. Birthplace Ireland,

16 (a) Informant Mrs. Wm. J. Brooksbank,
(b) Address 3344 Virginia Ave.

17 (a) burial (b) Date thereof 5/31/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Baltimore City

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 Park Heights Ave.

19 MAY 30 1947 (Date received by registrar) Courtenay Williams M.D.

V S 130

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29, 1947 19 , at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/10 1947 to 5/29/47 19 ,
and that I last saw her alive on 5/29 1947

Immediate cause of death Acute Cardiac Failure — Duration 1 da

Due to Cardiovascular Renal Disease — 3 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph L. Curtain
Address 679 Washington Blvd. Date signed 5/30/47

G52173

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 39 C

Registered No. G52173

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Maryland Rd - Herring Run
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 103 So. Franklintown Road (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Virginia Quinn

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. ~~Single~~ Married

6 (b) Name of husband or wife Laurence J. Quinn

6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) Aug 22 1905

8. AGE: Years 41 | Months 8 9 | Days 7 | If less than one day ____hr. ____min.

9. Birthplace Williamsport Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER
12. Name Walter W. Cusack
13. Birthplace unknown

MOTHER
14. Maiden Name Minnie M. Brewer
15. Birthplace unknown

16 (a) Informant Franz Filusch
(b) Address 103 So. Franklintown Rd. Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/31/47 (month) (day) (year)
(c) Cemetery or crematory Rose Hill
Location Hagerstown Md.

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

19 MAY 30 1947 (Registered by registrar) (b) Catherine for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1947, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 29 1947, to May 29 1947, and that I last saw h.e.r. alive on May 29 1947.

	Duration
Immediate cause of death: Respiratory failure	—
Due to: Rocky Mt. Spotted Fever	1 week.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. J. Little M.D.
Address Sydenham Hosp. Date signed 5/30/47

V S 150

File No. 52174

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G52174

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - 5
(If outside city or town limits, write RURAL and give town)
(d) Street No. 616 N. Chester St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dominic Lalli

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-01-4414

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife Antoinette

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 18 1897

8. AGE: Years	Months	Days	If less than one day
49	6	10	hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation

11. Industry or business Standard Sanitary Co.

FATHER: 12. Name ?
13. Birthplace Italy

MOTHER: 14. Maiden Name ?
15. Birthplace Italy

16 (a) Informant Antoinette Lalli (Wife)
(b) Address 616 N. Chester St.

17 (a) Burial (b) Date thereof May 31 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balt. Md.

18 (a) Funeral director Frank Dellarocco
(b) Address 52 N. Morley St.

MAY 30 1947 Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/28/1947 at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/20 1947 to 5/28 1947. and that I last saw him alive on 5/27 1947

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Bronchopneumonia	
Due to	
Other Conditions Auricular Fibrillation with acute myocarditis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address St Josephs Hosp Date signed 6/28/47

VS 150

G52175

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G52175

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edgewood Nursing Home
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 5 49
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3909 Georgia Ave. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Lydia R. Inatter

3 (b) If veteran, name war:

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Joseph M. Inatter

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Aug. 5 - 1866

8. AGE: Years: 81 | Months: 9. | Days: 24 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Maria Sayler
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. W. G. Blizzard
(b) Address 3909 Georgia Ave. Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 31 - 1947 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Baltimore

18 (a) Funeral director Jeannie Cook Syfer
(b) Address 1600 W. North Ave.

19 MAY 30 1947 (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1947. at 4.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 16 1947 to May 29 1947. and that I last saw her alive on May 28 1947

Immediate cause of death: Chronic cardio renal disease — Duration: 2 yrs.

Due to: Senile changes

Due to:

Other Conditions: Inguinal Hernia (Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature George D. Lisby M.D.
Address 1921 Pattenson Park Ave. Date signed 5/30/47

V S 130

G52176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √83a

Registered No. G52176

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4506 Frederick Road.
(c) Hospital or institution: Colonial Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 625 S. Franklintown Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Mc Cubbin

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Grayson H. McCubbin
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) December 1, 1881

8. AGE: Years 65 Months 5 Days 29 If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Joseph Fuller
13. Birthplace Maryland.

MOTHER
14. Maiden Name Anna Frazer
15. Birthplace Maryland

16 (a) Informant Mrs. Ruby B. Ricker
(b) Address 215 Beaumont Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-2-47 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location Baltimore, Maryland

18 (a) Funeral director George L. Schwab
(b) 1111 Frederick Ave.

19 (d) MAY 31 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30, 1947, at 12:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/14 1947, to 5/29 1947, and that I last saw her alive on 5/29/ 1947.

Immediate cause of death: Congestive Heart Failure — Pulmonary Edema — Duration 48 hrs.
Due to: Cerebral Accident — Hemiplegia — 4 mo.
Due to: Hypertension
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. Smith Jr. M. D.
Address 1933 E. Balto. St. Date signed 5/30/47

X

G52177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 116

Registered No. G52177

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ga (b) County
(c) City or town Vineaville (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lucien Carter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Hazel Be

6 (c) If widowed, give age years

7. Birth date of deceased (mo., day, yr.) 7-7-02

8. AGE: Years 44 | Months 10 | Days 23 | If less than one day hr. min.

9. Birthplace Ga (Town, county, and state)

10. Usual Occupation Furniture Dealer

11. Industry or business

FATHER
12. Name W. L. Carter
13. Birthplace Ga

MOTHER
14. Maiden Name Mamie Reddish
15. Birthplace Ga

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation or removal) (b) Date thereof May 30/47 (month) (day) (year)
(c) Cemetery or crematory Lexington Ga
Location

18 (a) Funeral director John G. Mitchell & Son
(b) Address 1900 Eutaw Place

19 (date received by Registrar) MAY 31 1947 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1947 at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 1947 to May 30 1947 and that I last saw h[illegible] alive on May 30 1947

Immediate cause of death: Hemorrhage from esophageal varices — Duration

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John H. Traeger M. D.
Address Johns Hopkins Hosp. Date signed 5/30/47

VS 150

652178 BH B27465 BALTIMORE CITY HEALTH DEPARTMENT 87E Registered 652178

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 614 S. Hanover St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rita Jane Gibson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26, 1945

8. AGE: Years	Months	Days	If less than one day
1	11	2	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Everett Gibson
13. Birthplace W.Va.

MOTHER
14. Maiden Name Lorraine Newell
15. Birthplace W.Va.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 5 31 47 (month) (day) (year)
(c) Cemetery or crematory GLEN HAVEN.
Location RITCHIE HIGHWAY

18 (a) Funeral director JOHN F. DEANY, INC.
(b) Address 315 LIGHT ST.

19 (a) MAY 31 1947 (Date rec'd by registrar) Interim for Williams, M.E.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 19 47, at 3.20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-27 1947 to 5-28 19 47, and that I last saw h. alive on 5-28- 19 47.

Immediate cause of death: Ether Anesthesia — Duration 25 min.
Due to:
Due to:
Other Conditions: Congenital Spastic Diplegia — 23 mos
(Include pregnancy within 3 months of death)
Date of operation May 28 47
Major findings of operation: High Myopia
of autopsy: Dec. grave - hg. thymus, interstitial pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: Accident 26-V
(b) Date of occurrence 5/28/47 at 3 P.M.
(c) Where did injury occur? City Hosp. Baltimore Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public (Specify type of place) While at work? no
(e) Means of injury: Intubation Anesthesia - operation

23. Signature: Julian P. Griffin M. D.
Address Balt City Hosp. Date signed

VS 150

To be approved by Medical Examiner
Dr C J. Labinski per Howard J. Sheldon, M.D. 29 May '47

G52179

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G52179

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Hartford Rd
(c) Hospital or institution: Hartford Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 510 London Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary M. Schneider

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 23rd 1857

8. AGE: Years	Months	Days	If less than one day
89	11	5	hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation Home

11. Industry or business

FATHER
12. Name Frederick Schneider
13. Birthplace Germany

MOTHER
14. Maiden Name Margaretta Miller
15. Birthplace Germany

16 (a) Informant John H. Schneider (Brother)
(b) Address 6211 Ground Ave (Mo 3498)

17 (a) Burial (b) Date thereof 5/31/47
(Burial, cremation, removal) (month) (day) (year)

(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 217 St. Paul St.

19 MAY 31 1947 Huntington Williams Md
(Date of this record) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28th 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1946 to May 1947, and that I last saw h[illegible] alive on May 29 1947.

Immediate cause of death	Duration
Cardio-vascular-renal disease	
Due to Senility	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. L. Ewald Jr.
Address 36 York Ct. Date signed 5/29/47

VS 150

G52180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 133a

Registered No. G52180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2524 Aisquith St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward C. Yeager

3 (b) If veteran, name war NN

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Thelma Yeager
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 17 1898

8. AGE: Years	Months	Days	If less than one day
48	7	11	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Supt. Construction
11. Industry or business Md. Steel Products Co.

FATHER
12. Name Charles Yeager
13. Birthplace Pa.

MOTHER
14. Maiden Name Ella Hughes
15. Birthplace Balto. Md.

16 (a) Informant Thelma Yeager
(b) Address 2524 Aisquith st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/2/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) MAY 31 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/28 1947, at 11 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/27 1947 to 5/28 1947, and that I last saw him alive on 5/28 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Uremia	
Due to Renal Insufficiency Polycystic Kidneys	
Other Conditions Pyelonephritis & pyonephrosis & peritonitis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harold M. Gordon M. D.
Address Sinai Hosp. Date signed 6/2/47

G52181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G52181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 133 Siegwart Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 133 Siegwart Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Matthew J. Mackbee

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	215-01-5470

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Rose C. Mackbee
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/10/1887

8. AGE: Years	Months	Days	If less than one day
59	9	19	hr. min.

9. Birthplace Annapolis, Maryland
(Town, county, and state)
10. Usual Occupation Glazier
11. Industry or business

FATHER
12. Name Matthew J. Mackbee
13. Birthplace Annapolis, Maryland

MOTHER
14. Maiden Name Annie Colburn
15. Birthplace Annapolis, Maryland

16 (a) Informant Mrs. Rose C. Mackbee
(b) Address 133 Siegwart Lane

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 6/2/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) Date received by Local Registrar MAY 31 1947 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29, 1947, at 11:15 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/25 19 47 to 5/29 19 47
and that I last saw h[illegible] alive on 5/29 19

Immediate cause of death	Duration
Coronary insufficiency	1 hour
(coronary)	
Due to	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Wilkes M. D.
Address 2030 Wilkes Ave Date signed 5/30/47

052182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 51B

Registered No. G52182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4800 Cranson Ave Towson #12
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Allen B. Williamson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 15, 1863

8. AGE: Years	Months	Days	If less than one day
83	7	15	hr. min.

9. Birthplace Ohio
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Platt Williamson
13. Birthplace

MOTHER
14. Maiden Name Bessie W. Allen
15. Birthplace

16 (a) Informant Lena B. Williamson
(b) Address 4800 Cranson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-7-47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Williamson & Son
(b) Address 2424 Pont St

19 MAY 31 1947 (Date filed by Registrar) (b) Huntington Williams M.D. (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1947. at 12:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 9 1947 to May 30 1947. and that I last saw him alive on May 24 1947.

Immediate cause of death	Duration
Carcinoma of Bladder & Prostate	
Carcinoma of Prostate	
Due to	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	

Date of operation May 26 1947
Major findings of operation: Carcinoma of Bladder & Prostate
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward T. Burkhart M. D.
Address Maryland Trust Bldg Date signed May 30, 1947

VS 150

C52183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C52183

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1311 S. Highland Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1311 S. Highland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie Mugford.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widowed

6 (b) Name of husband or wife Wm. J. Mugford
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 19 - 1872

8. AGE: Years	Months	Days	If less than one day
75	1	8	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation at Home
11. Industry or business —

FATHER
12. Name Evan Mugford
13. Birthplace Wales

MOTHER
14. Maiden Name Ellen Turner
15. Birthplace Balto. Md.

16 (a) Informant Joseph Leitzer & Howard Mugford
(b) Address Elliott St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/31/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Dogwell St.

18 (a) Funeral director John D. Connelly.
(b) Address 418 Eastern Ave.

19 MAY 31 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from — 1943, to 5/26 1947, and that I last saw h.s.v. alive on 5/26 1947.

Immediate cause of death ~~Acute Cardiac~~ Coronary Disease — Duration ~~—~~ 4 yrs.
Due to Arteriosclerosis — Duration 4 yrs.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. Frank Meamen, M. D.
Address 222 S. Eden St. Date signed 5/28/47

VS 190

X

G52184

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

Registered No. G52184

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 hours
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1118 E 36th St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John William Bersterman (John William Bersterman)

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 212-24-9941

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: ~~Marie Rioss~~

39 ~~Yrs.~~ alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) June 26 1905

8. AGE: Years 41 | Months 11 | Days 3 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Railway Express

FATHER — 12. Name Samuel A. Bersterman

13. Birthplace Balt. Md

MOTHER — 14. Maiden Name Barbara Bersterman

15. Birthplace Balt. Md ~~Bersterman~~

16 (a) Informant Mrs. Barbara Bersterman

(b) Address 1603 Asquith St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/2/47 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Road, Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.

(b) Address 1735 Harford Avenue

19 MAY 31 1947 (Date rec'd by registrar) (b) Hunting for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1947, at 1:40A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 28 1947 to May 29 1947 and that I last saw h/m alive on May 29 1947

Immediate cause of death: Shock — Duration 6 hrs

Due to: Hemorrhage from esophageal varices + stomach — Duration 7 days

Due to: Cancer Cirrhosis — Duration years

Other Conditions: Chronic Alcoholism

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Of hem. Cancer Cirrhosis

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Winston Kunkel, M.D.

Address Union Mem. Hosp. Date signed 5-29-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the exact causes of death clearly and legibly.

G52185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

G52185
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore,
(c) City or town Catonsville,
(If outside city or town limits, write RURAL and give town)
(d) Street No. South Rolling Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNE E DORSEY

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Stanley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept 6. 1884

8. AGE: Years 62 65 | Months 8 | Days 23 | If less than one day hr. min.

9. Birthplace: Carroll Co Md
(Town, county, and state)

10. Usual Occupation: Housewife
11. Industry or business:

FATHER
12. Name: John F Day
13. Birthplace: Md

MOTHER
14. Maiden Name: Elizabeth J Leatherwood
15. Birthplace: Md

16 (a) Informant: Harrison Day
(b) Address: Westminster Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/1/47 (month) (day) (year)
(c) Cemetery or crematory: Mogan Chapel
Location: Westminster Md

18 (a) Funeral director: Wm E Roe & Son
(b) Address: Sykesville Md

19 MAY 31 1947 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29, 1947, at 5 P. M

21. I certify that I took charge of the remains described above, held an Partial Autopsy & Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fractured skull,
Intracranial hemorrhage, Fractured femur,
Extensive lacerations of left leg and foot
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was ~~primary~~ ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-29-47 at 4:43 P. M. Catw. Sq.
(b) Where did injury occur? Ingleside Rd. & By Pass #40
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Auto. & Tractor-trailer collided

23. Signature: George E Merrill M.D.
Medical Examiner.
Date signed 5-30-47

VS 181

G52186
AE-103004

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G52186

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10mos- 1day
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 114 Albmarles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Sullivan

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 28- 1865

8. AGE: Years 81 | Months 8 | Days 21 | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Patrick Sullivan
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherina Hunt
15. Birthplace Ireland

16 (a) Informant Record-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 5/31/47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Loudon Park Road

18 (a) Funeral director J. Slater Payne
(b) Address 318 Light St.

19 MAY 31 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19- 1947, at 4.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-18 1946, to 5-19 1947, and that I last saw him alive on 5-19 1947.

Immediate cause of death: Carcinoma of Stomach with metastases — Duration: Unknown
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 3-27-47
Major findings of operation: Adenocarcinoma
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice M. Lacy, M.D.
M. D.
Address Baltimore City Hospitals Date signed 5-19-47

G52187
AB-15969

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 107

Registered No. G52187

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25yrs-8mos. 3days
(e) Length of stay in Baltimore (yrs., mos., or days) 42yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 711 S. Wolfe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Mraczwski

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Marian Tunas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870 -or 1875 1873

8. AGE: Years	Months	Days	If less than one day
72-or-77	?	?	hr. min.

9. Birthplace Poland
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Martin Mraczwski
13. Birthplace Poland

MOTHER
14. Maiden Name Josephine Komar
15. Birthplace Poland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/31/47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Bergen Blvd & Fairview Ave

18 (a) Funeral director J. Fabian Lynch
(b) Address 3118 Eight St.

19 MAY 31 1947 (Date filed by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION AM

20. DATE OF DEATH May 27 1947, at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-24-24 19 24 to 5-27-47 19 47, and that I last saw h. in alive on 5-27 1947

Immediate cause of death	Duration
Congestive Heart Failure, Pulmonary Edemea & bilateral bronchopneumonia	4-5 days
Due to Marked generalized Arteriosclerosis	
Due to	
Other Conditions Arteriosclerotic Gangrene left foot	

(Include pregnancy within 3 months of death)
Date of operation 5-21-47
Major findings of operation: Arteriosclerotic Gangrene left foot
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Bailes M. D.
Address City Hospitals Date signed 5-30-47

V S 150

052188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121a

Registered No. 052188

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 405 N. Broadway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 405 N. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fredericka Siegmund

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Charles Siegmund
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17, 1850

8. AGE: Years	Months	Days	If less than one day
97	1	13	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Charles Ortman
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline-
15. Birthplace Maryland

16 (a) Informant Ferdinand Siegmund
(b) Address 3017 Weaver Ave.

17 (a) Burial (b) Date thereof 6/2/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md.

18 (a) Funeral director Ullrich Funeral Home,
(b) Address 2008 Orleans St.,

19 (Registrar's signature) Huntington Williams M.D.
(Registrar)
MAY 31 1947

MEDICAL CERTIFICATION A

20. DATE OF DEATH May 30, 1947 19 , at 4:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1947, to May 30 1947, and that I last saw h[illegible] alive on May 29 1947

Immediate cause of death
My o cardial Infarct
Due to Chronic My o cardites.
Mitral Insufficiency
Cardio - Vascular - Renal
Due to arterio - Sclerosis -
Other Conditions

Duration
May 3/47
—
—
—
—

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis J. Tremonti M. D.
Address 722 N. Kenwood Date signed May 30/47

V S 150

G52189

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G52189 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2702 The Alameda
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 1/
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
City or town 2702 The Alameda
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Neumann

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Laura Pohle
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Oct 23 1873

8. AGE: Years 74 | Months 3 | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Wheelwright

11. Industry or business Self

FATHER
12. Name John Neumann
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Hartman
15. Birthplace Germany

16 (a) Informant Laura Neumann
(b) Address 2702 The Alameda

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 2 (month) (day) (year)
(c) Cemetery or crematory Pgr Memorial Park
Location Rural

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans

19 (a) MAY 31 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29th 1947, at 3 30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/26 1947, to 5/29 1947, and that I last saw him alive on 5/29 1947.

Immediate cause of death: Coronary thrombosis — Duration 1 hr

Due to Coronary sclerosis — 4 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature H A Burden M. D.
Address 517 E 20th St Date signed 5/30/47

X

G52190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

Registered No. G52190

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or Institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give county)
(d) Street No. 1029 Bennett Pl.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Thornton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 64 | Months | Days | If less than one day hr. min.

9. Birthplace Reisterstown Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name William Thornton
13. Birthplace Md.

MOTHER 14. Maiden Name Alice Jones
15 Birthplace Md

16 (a) Informant Dept. of Records
(b) Address 1514 Division St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-1-47 (month) (day) (year)

(c) Cemetery or crematory Mt. Zion Cemetery
Location Balto. Md.

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave (b) Huntington Williams, Mgr

MAY 31 1947 (Date certificate filed) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28, 1947, at 11:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-8 1947 to 5-28 1947 and that I last saw h[illegible] alive on 5-28 1947

Immediate cause of death	Duration
Pyloric obstruction	
Due to Tumor of pylorus end of stomach	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: ~
of autopsy: Ca of stomach

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature I. B. Higgens M.D.
Address Provident Hosp Date signed 5-29-47

VS 190

C52191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83B

Registered No. C52191

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1018 N. Rutland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Coalet Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26-1944

8. AGE: Years	Months	Days	If less than one day
3	1	3	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation to

11. Industry or business

FATHER 12. Name Jessie L Davis

13. Birthplace N C

MOTHER 14. Maiden Name Josephine Miller

15. Birthplace Balto Md

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 31-1947 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cemetery

Location Balto Md

18 (a) Funeral director Robert E Williams

(b) Address 1515 McElderry St

19 (a) Washington Blvd Baltimore Md

Registered by MAY 31 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1947, at 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 29 1947, to May 29 1947, and that I last saw h alive on May 29 1947.

Immediate cause of death	Duration
Sudden Cell Anemia	
Due to Intra-cranial Thrombosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Rosenquist M. D.

Address Date signed

BARRETT

G52192

HEALTH DEPARTMENT—CITY OF BALTIMORE G52192

CERTIFICATE OF DEATH ✓ 83a

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 417 E. Lafayette Ave St. Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Oda Barrett If U. S. Veteran specify WAR

(a) Residence: No. 417 E Lafayette Ave St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	Colored	

3a. If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Barrett

6. DATE OF BIRTH (month, day, year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
62 1885	Jan 4	18 11	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Domestic

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Maryland

FATHER

13. NAME James Bond

14. BIRTHPLACE (city or town) (State or country) Maryland

MOTHER

15. MAIDEN NAME Rachel Johnson

16. BIRTHPLACE (city or town) (State or country) Maryland

17. INFORMANT Marietta Stewart
(Address) 502 Barclay

18. BURIAL, CREMATION, OR REMOVAL Christ
Place Pleasant Rest Cem. June 2 1947

19. UNDERTAKER Mrs. Lottie Gross
(Address) 417 Eutaw Ave.

20. MAY 31 1947 Washington Hill M.D.

VS 2

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 5-29-1947

22. I HEREBY CERTIFY, That I attended deceased from May 28 1947 to May 29 1947

I last saw her alive on May 27 1947. Death is said to have occurred on the date stated above, at 7 P m.

The principal cause of death and related causes of importance were as follows:

	Interval between onset and death
Cerebral hemorrhage	May 28
Other contributory causes of importance	

Was an operation performed? No Date of

For what disease or injury? —

Name of operation

What test confirmed diagnosis? By Ex Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) R Garland Shipley M. D.

(Address) 1534 Druid Hill Ave

X

G52193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 108

Register G52193

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town).
(d) Street No. 504 Colgate Way (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Melvin Griffin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Married

6 (b) Name of husband or wife Ida Griffin
6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) July 16, 1906

8. AGE: Years	Months	Days	If less than one day
39 40	10	12	hr. min.

9. Birthplace Middlesex, Virginia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Ida Griffin
(b) Address 504 Colgate Way, Dundalk

17 (a) Burial (b) Date thereof May 01, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Chas. Sumner L. Stansbury
(b) Address 1637 Druid Hill Ave.

MAY 31 1947 Washington Williams, Md.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 1947, at 4:?? PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 20 1947, to May 28 1947, and that I last saw h. alive on May 28 1947.

Immediate cause of death	Duration
Pulmonary Embolism	
Due to Pneumonia	
Due to	over
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Emboles in left pulmonary

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Grant C. Smith M. D.
Address 1514 Division St. Date signed 5-29-47

X

G52194 D.O.A. - AM #67681

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

Registered No. G52194

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct are is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6117 Toone St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Linda Ann Buhrman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 9- 1947

8. AGE: Years	Months	Days	If less than one day
	4	21	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Raymond Buhrman
13. Birthplace Md.

MOTHER
14. Maiden Name Ruth Buhrman
15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 1, 1947 (month) (day) (year)
(c) Cemetery or crematory Bruns Hill, Camp.
Location Westminster, Md.

18 (a) Funeral director Walter J. Crouse
(b) Address Westminster, Md.

MAY 31 1947 Washington Williams, M.D. Registrar
(Date received by Registrar)

V S 190

MEDICAL CERTIFICATION AM

20. DATE OF DEATH May 30 1947, at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-27-47 19 to 5-27-47 19, and that I last saw him alive on 5-27 1947

Immediate cause of death Diarrhea, Pulmonary Edema, Bronchopneumonia

Due to Sensitivity to cow's Milk

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pulmonary Edema, Pneumonia

Duration
Diarrhea
3 Months

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Barnhart M. D.
Address Balt. City Hosp. Date signed 5-31-47

To be approved by the Medical Examiner
Howard J. Madeira, M.D.

G52195

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G52195

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1213 W. Lafayette Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Ann Henson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Louis Henson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20, 1861

8. AGE: Years 86 | Months 1 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Solomon Ennis
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Rosalya Allen (Granddaughter)
(b) Address 1223 W. Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 2 - 47 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director James A Hayes
(b) Address 142 Mosher St

19 MAY 31 1947 Huntington Williams, M.D.
(Date received by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1947, at 3 5/4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19, to 19, and that I last saw h[illegible] alive on May 29 1947.

Immediate cause of death	Duration
Arteriosclerotic Heart Disease	
Due to	
Due to	
Other Conditions Primary Carcinoma of the Liver (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M Ewalaro M. D.
Address 803 Arlington Ave Date signed 5-31-47

VS 150

SIKORSKI

G52196

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. G52196

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 dy
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 419 S. Bond St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Sikorski

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-09-8963

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Agnes

6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) 6-27-93

8. AGE: Years 55 | Months 11 | Days 2 | If less than one day ____ hr. ____ min.

9. Birthplace Md. Poland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Stanley Sikorski
13. Birthplace Md. Poland

MOTHER
14. Maiden Name Sophia ?
15. Birthplace Md. Poland

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-2-47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location Baltimore County Md

18 (a) Funeral director George A. Weber
(b) Address 705 S. Amity st

19 MAY 31 1947 (b) Huntington Williams, M.D.
(Date received by Registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1947 at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 14 1947 to May 29 1947 and that I last saw deceased alive on May 29 1947

Immediate cause of death: Carcinoma of branchus — Duration: 1 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E. Mason M. D.

Address Johns Hopkins Hosp Date signed 29 May '47

G52197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G52197

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 706½ W. Fairmount Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 706½ W. Fairmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Monroe Black.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race C. | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Lillie Mae Black

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 27, 1905

8. AGE: Years 41 | Months 5 | Days | If less than one day ____hr. ____min.

9. Birthplace Darlington, S.C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Ellie Black

13. Birthplace Darlington, S.C.

MOTHER 14. Maiden Name Luda Greene

15. Birthplace Darlington S.C.

16 (a) Informant Lillie Mae Black

(b) Address 706½ W. Fairmount

17 (a) Burial (b) Date thereof May 31, 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director Mrs Katie R Kelly

(b) Address 322 E. Lexington St

19 (a) MAY 31 1947 (b) Huntingtown, Maryland
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1947, at 3 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 26 1947 to May 27 1947 and that I last saw h[illegible] alive on May 27 1947.

Immediate cause of death	Duration
Coronary Heart Disease	2 weeks
Due to Hypertension	
Due to Cerebral Vascular Lesions	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. W. Northrop, M.D.

Address 726 N. Eden St Date signed 5/29/47

VS 150

G52198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G52198

131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 313 N. Carrollton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 313 N. Carrollton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah S. Campbell.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	Widow.

6 (b) Name of husband or wife William Campbell.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2, 1883

8. AGE: Years	Months	Days	If less than one day
64	1	26	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Benjamin Linnell
13. Birthplace Calvert Co., Md.

MOTHER
14. Maiden Name Sarah Thomas
15. Birthplace Calvert Co., Md.

16 (a) Informant Sarah Brown
(b) Address 313 N. Carrollton Ave

17 (a) Burial (b) Date thereof 6-2-1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) MAY 31 1947 Huntington Williams Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 1947, at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1947 to May 28 1947 and that I last saw h alive on May 28 1947

Immediate cause of death: Chronic Myocarditis
Chronic Nephritis

	Duration
Due to	
Due to	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Hoskell M.D.
Address 604 N. Carrollton Ave Date signed 5/29/47

VS 150

052199

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 052199

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PERSON RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 525 S. Sharp St.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 525 S. Sharp St., (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mollie Parham.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Payton Parham

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 1862.

8. AGE: Years 65 | Months 4 | Days | If less than one day hr. min.

9. Birthplace Prince George Co., Va. (Town, county and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Robert Taylor.

FATHER 13. Birthplace Prince George Co., Va.

MOTHER 14. Maiden Name Jones ?

MOTHER 15. Birthplace Prince George Co. Md.

16 (a) Informant Gertrude Jackson.

(b) Address 525 S. Sharp St.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 5-31-1947. (month) (day) (year)

(c) Cemetery or crematory Dispatanta

Location Virginia

18 (a) Funeral director Mrs Katie R Williams

(b) Address 322 N Sycamore St

19 (a) MAY 31 1947 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/28 1947 12:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/26/47 to 5/28 1947 and that I last saw ... alive on ... 19...

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howell Long M. D.

Address 1131 Harlem Ave. Date signed 5/28/47.

G52200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G52200

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 18 Poultney St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 18 Poultney St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Henry Reese

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-48-3193

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary E. Reese (Nee Boehmer) 6 (c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) July 21, 1869

8. AGE: Years 77 | Months 10 | Days 8 | If less than one day ____ hr. ____ min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Making in Shipping Dept

11. Industry or business W. J. G. Baines & Co.

FATHER 12. Name Thomas Reese

13. Birthplace Germany

MOTHER 14. Maiden Name ? Blainey

15. Birthplace Va.

16 (a) Informant Mrs. Mary E. Reese (Wife)

(b) Address 8 Poultney St., Balto. 30, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 31, 1947 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Balto., Md.

18 (a) Funeral director A. Howard Evans

(b) Address 1405 E. Chase St. Balto. 39, Md.

MAY 31 1947 (Date received by registrar) (b) Huntington Williams, M.D. (Signature of registrar)

MEDICAL CERTIFICATION 10:30

20. DATE OF DEATH May 29, 1947 at A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1947 to May 29 1947 and that I last saw him alive on May 29 1947.

Immediate cause of death	Duration
Coronary Heart disease	1 mo
Due to Arteriosclerosis	
Due to	
Other Conditions Chronic kidney Condition (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
(f) Signature Isaac Miller M.D.
Address 124 E. Chase St. Date signed

V S 150

Isaac Miller 5/30/47.

G52201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G52201

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 920 S. Robinson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 920 S. Robinson St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Kucharek

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W	Married

6 (b) Name of husband or wife Frances Kucharek
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years	Months	Days	If less than one day
79	-	-	....hr. ....min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Stanislaw Kucharek
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Poland

16 (a) Informant Mrs. Frances Kucharek
(b) Address 920 S. Robinson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-2-47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Gunpowder Hill Road

18 (a) Funeral director John J. Doyle
(b) Address 1849 Fulton St.

19 MAY 31 1947 (Date received by Registrar) (b) Certificate for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-30-1947, 12:20 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-2-1946 to 5-30-1947 and that I last saw h alive on 5-30-1947

Immediate cause of death	Duration
Arteriosclerotic C.V. Disease	
Chronic myocarditis	12-2-46
Due to Acute Coronary Occlusion	5-30-47
Due to	
Other Conditions Nil	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
Nil
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Eric Schemmerhorn M. D.
Address 942 S. Exeter Date signed 5-31-47

V S 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52202

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1790

Registered No. G52202

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Calif. (b) County
(c) City or town Hollywood (If outside city or town limits, write RURAL and give town)
(d) Street No. 5622 Bryson Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Burton McClay

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1915

8. AGE: Years	Months	Days	If less than one day
32			hr. min.

9. Birthplace Denver, Colorado. (Town, county, and state)

10. Usual Occupation Chief Steward

11. Industry or business Merchant Marine

FATHER
12. Name J. Coy McClay
13. Birthplace Unknown

MOTHER
14. Maiden Name Jessie R McMahon
15. Birthplace Unknown.

16 (a) Informant Booker McClay.
(b) Address Washington D.C.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof May 31, 1947 (month) (day) (year)
(c) Cemetery or crematory Greenmount.
Location Greenmount Ave & North

18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 St Paul St.

MAY 31 1947 (Date rec'd by registrar)

19 (a) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1947, at 1:30 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Methyl alcohol poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 5-27-47

VS 181

G52203

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G52203

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully examined before the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1801 Westphal Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1801 Westphal Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Schwarz Sr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Mary Schwarz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 8 - 1872

8. AGE: Years 74 | Months 9 | Days 20 | If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Enamel Burner

FATHER 12. Name Unknown

13. Birthplace Unknown

MOTHER 14. Maiden Name Unknown

15. Birthplace Unknown

16 (a) Informant Mr Charles Schwarz Jr

(b) Address 1801 Westphal Pl.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/31/47 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location Brooklyn Md

18 (a) Funeral director Wm L Berger & Sons

(b) Address 1201 Collins St

MAY 31 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/28 1947, at 6:35 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiac Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature C. L. Faulkner M.D.
Medical Examiner.

Date signed 5/29/47

VS 181

G52204

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G52204

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Lombard & Greene Sts
(c) Hospital or institution: Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1820 W. Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph J Kramer KRAMER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch 15 1875

8. AGE: Years 72 | Months 2 | Days 14 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER 12. Name John Kramer

13. Birthplace Germany

MOTHER 14. Maiden Name Margaret Long

15. Birthplace Germany

16 (a) Informant Nebraska Kramer

(b) Address 1820 W Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-31-47 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Balto Md

18 (a) Funeral director Guy A Bayley

(b) Address Fulton & Bayley

19 MAY 31 1947 (Date rec'd by registrar) (b) Huntington Williamson, W.Va.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1947 at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 29 1947 to May 29 1947 and that I last saw h.l.ve. alive on May 29 1947.

	Duration
Immediate cause of death: Cardiac failure	
Due to: Coronary Thrombosis	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jeanne A. Vaughn, Jr. M.D.

Address Univ. Hospital Date signed M. D. 5-29-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

G52205

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

Registered No. G52205

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 115 S. Castle Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 115 S. Castle Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sophia B. Hand

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 21-1883

8. AGE: Years	Months	Days	If less than one day
64	1	10	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Charwoman
11. Industry or business

FATHER
12. Name Julius Fesker
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Altenheimer
15. Birthplace Germany

16 (a) Informant Edward Hand
(b) Address 120 S. Wolfe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/6/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Lilly + Zeiler
(b) Address 443 S. Wolfe St.

19 (a) JUN 3 - 1947 (Date rec'd by registrar) Huntington Hollins

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 1947, at 1:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 29 1947 to June 1 1947 and that I last saw h[illegible] alive on June 1 1947.

Immediate cause of death	Duration
Carcinoma of Sigmoid	
Intestinal Obstruction	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward Hunkins

Address 2579 Eastern Ave Date signed 6/7/47

VS 150

G52206

AB-111024

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 157E

Registered No. G52206

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4hrs. 5min
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 314 Sollers Point Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Loretta Humbles

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23-1947

8. AGE: Years	Months	Days	If less than one day
0	0	6	0 hr. 5 min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Alfred Humbles
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Cousins
15. Birthplace Va.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Removal (b) Date thereof May 31 / 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Approximately County Va

18 (a) Funeral director Mr. Pitt A. Gladstone Dept
(b) Address 1129 E. Cardenas St

19 (a) MAY 31 1947 (b) Burial permit issued by Registrar Huntington Williamsport, Md.

VS 150

MEDICAL CERTIFICATION PM

20. DATE OF DEATH May 29 19 47 at 4.50 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 29 19 47 to May 29 19 47 and that I last saw h. 9F alive on May 29 19 47

	Duration
Immediate cause of death: Congestive Heart Failure	18 hrs
Due to: Congenital Heart Disease	6 days
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Tri-locular heart

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nathan P. Griffin M. D.
Address Balt. City Hospitals Date signed 30 May 1947

G52207 G52207

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dept
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1647 E Fayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Reddick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years 52 | Months | Days | If less than one day hr. min.

9. Birthplace Norfolk Va
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace " "

MOTHER
14. Maiden Name Unknown
15. Birthplace " "

16 (a) Informant Maggie Chaffin
(b) Address 1647 E Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 31-47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cem
Location Brooklyn Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1010 E Huntley ave

19 (a) JUN 1 1947 (Date rec'd by Registrar) (b) Signature of Registrar Wilfred M. Trar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1947 3:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. F. Lukenbill M.D.
Medical Examiner.
Date signed 5/26/47

VS 191

G52208

514417.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G52208 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Monty.
(c) City or town Silver Spring (If outside city or town limits, write RURAL and give town)
(d) Street No. 709 Spring St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur E Peck.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male. 5. Color or race: White. 6 (a) Single, married, widowed, or divorced: widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-7-78

8. AGE: Years 69 Months Days 27 If less than one day hr. min.

9. Birthplace Mo. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Percival Peck.

13. Birthplace Mich

MOTHER 14. Maiden Name Sarah Linton

15. Birthplace Ohio

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/1/47 (month) (day) (year)

(c) Cemetery or crematory Mt. Hope
Location Independence, Kansas

18 (a) Funeral director John F Denny Sec
(b) Address 415 Light St.

19 (a) (b) Registrar
(Date filed by registrar)

JUN 1 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May - 29 - 1947, at 11.00 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 29 1947, to May 29 1947, and that I last saw him alive on May 29 1947.

Immediate cause of death	Duration
Acute heart failure	
Due to Arteriosclerotic heart disease	
Due to	
Other Conditions Diabetes, hypertension	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice B Winstead M.D.
Address J H H Date signed 30 May 47

937

G52209

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G52209 Registered No. 170c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1809 N. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas F. Wilson

3 (b) If veteran, name war: World War #2
3 (c) Social Security Account No. 230-16-7226

4. Sex: M
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: —
6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) May 2 - 1923

8. AGE: Years 24 | Months 0 | Days 28 | If less than one day ____ hr. ____ min.

9. Birthplace: Galax Virginia (Town, county, and state)
10. Usual Occupation: Handyman
11. Industry or business: Chevrolet General Motors

FATHER
12. Name: Walter B. Wilson
13. Birthplace: Dalton Va

MOTHER
14. Maiden Name: Verna Davis
15. Birthplace: Galax Va.

16 (a) Informant: Mrs. John Robert Wilson
(b) Address: Va State Police Alexandria

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 3-47 (month) (day) (year)
(c) Cemetery or crematory: Galax Virginia
Location: Galax Virginia

18 (a) Funeral director: H. Lander & Sons.
(b) Address: 1628 E. Fayette

19 JUN - 1 1947 (Date rec'd by Reg.) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31, 1947, at 5:15 A.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Broken neck. Subarachnoid Hemorrhage.

Due to:

Other Conditions: Multiple fractures, laceration, [illegible] etc.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5/30/47 at 10 P.M.
(b) Where did injury occur? Howard & 21st Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury: auto & motorcycle collision

23. Signature: Howard J. McDevitt M.D. Medical Examiner.
Date signed 5/31/47

VS 191

G52210

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G52210 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4048 Park Heights ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4048 Park Heights ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3 (a) FULL NAME Benjamin Mendelson

3 (b) If veteran, name war: —

3 (c) Social Security Account No. 212-03-5318

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	married

6 (b) Name of husband or wife Rebecah Mendelson
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) December 6-1892

8. AGE: Years	Months	Days	If less than one day
54	5	24	____ hr. ____ min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business Mens clothing

FATHER
12. Name Yoshe Leib Mendelson
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah Shane
15. Birthplace Russia

16 (a) Informant Mrs. Rebecah Mendelson
(b) Address 4048 Park Hghts ave

17 (a) ____ (Burial, cremation, or removal) (b) Date thereof ____ (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location ____

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-26 W North Ave

19 (a) ____ (Date received by Registrar) (b) Armington Williams, M.D. Registrar

JUN 1 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1947, at 1:05 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1947 to May 30 1947 and that I last saw him alive on May 30 1947

Immediate cause of death	Duration
Coronary Occlusion	several years
Diabetes, arteriosclerosis	
Due to	
Due to	
Other Conditions Bronchial asthma	

(Include pregnancy within 3 months of death)

Date of operation ____
Major findings of operation: ____
of autopsy: ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____ (Specify type of place)
(e) Means of injury ____

23. Signature Benjamin Kadin M. D.
Address 2306 Eutaw Pl Date signed 5-30-47

X

G52211

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G52211 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 208 S. Eutaw St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 d
(e) Length of stay in Baltimore (yrs., mos., or days) Not Known

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 208 S. Eutaw St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alfred E. Hoffman

3 (b) If veteran, name war: Spanish American
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband/wife: Francis Hoffman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 14-1865

8. AGE: Years 82 | Months 2 | Days 15 | If less than one day ____ hr. ____ min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Hotel Keeper
11. Industry or business

FATHER
12. Name Hoffman
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Bertha B. Bell
(b) Address 208 S. Eutaw St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 2-47 (month), (day), (year)
(c) Cemetery or crematory Balto. National Cem.
Location Frederick Rd.

18 (a) Funeral director John A. Miller
(b) Address 2334 Jefferson St.

19 (a) 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1947, at 11:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1947 to May 29 1947 and that I last saw h— alive on May 29 1947.

Immediate cause of death	Duration
Acute Cardiac failure	May
Due to	
Due to Cardio vascular disease renal	3
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1420 Mad Ave Date signed 5-31-47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52212
TH.

BALTIMORE CITY HEALTH DEPARTMENT
110956 CERTIFICATE OF DEATH 1937

G52212
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 208 Madeira St. Madeira
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Seperated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 5th 1900

8. AGE: Years	Months	Days	If less than one day
46	6	23	hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Barrett
13. Birthplace Va.

MOTHER
14. Maiden Name ? Lawrence
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 2-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cem.
Location E. Donnell St.

18 (a) Funeral director John A. Miller
(b) Address 2334 Jefferson St

19 (a) 1947 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28th 1947 19 , at 4.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 26/ 19 47 to May 28 19 47 and that I last saw h er alive on May 28 19 47

Immediate cause of death	Duration
Respiration Failure	3 days
Cerebral vascular accident	
Due to Hypertensive C.V.D.	yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edmund Callan M. D.
Address Balto City Hosp Date signed 29 May 47

Huntington Williams, M.D.

X

G52213 ARCHIE BRIDGEFORTH. G52213

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 164 c

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or Institution: Mercy Hospital DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town, write RURAL and name town)
(d) Street No. 1702 Latrobe St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (ARCHIE) Archibald Bridgeforth

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1947, at 1:50 P M

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) — — 1893

8. AGE: Years 54 | Months | Days | If less than one day ____hr. ____min.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Gun Shot Wound of Head, self inflicted

Due to

Other Conditions

(Include pregnancy within 3 months of death)

9. Birthplace Kenbridge Va
(Town, county and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Archie Bridgeforth
13. Birthplace Va

MOTHER 14. Maiden Name Willie Amy White
15. Birthplace Va

16 (a) Informant Henry Bridgeforth
(b) Address 320 Rockaway Ave Brooklyn NY

17 (a) Burial (b) Date thereof 6 3 47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Balto Nat Cem
Location Baltimore Md

18 (a) Funeral director Williams & Jackson
(b) Address 916 Penna ave

19 (a) — 1947 (b) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 24 May 1947 at 1:50 P.M.
(b) Where did injury occur? 1702 Latrobe St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Shot self in head with shot gun

23. Signature Wilhelmus F Reifsnyder M.D.
Medical Examiner.
Date signed 27 May 1947

VS 151

G52214

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G52214

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1610 W North Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1610 W North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas H. Hall

3 (b) If veteran, name war

3 (d) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-11-1869

8. AGE: Years	Months	Days	If less than one day
78	—	19	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Thomas A Hall
13. Birthplace Md

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs Vivian H Bundy
(b) Address 1910 Madison ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-1-47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location Baltimore Md

18 (a) Funeral director William A Jackson
(b) Address 916 Pennsylvania ave

19 (a) 1-1947 (Date received by registrar) (b) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1947, at 2:00 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William S Heffner M.D.
Medical Examiner.
Date signed May 31, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52215

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

G52215 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 17 N. Norris St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 17 N. Norris St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MAMIE WHITE JOHNS

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Married

6 (b) Name of husband/wife Hezekiah
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/30/1899

8. AGE: Years	Months	Days	If less than one day
47	7	28	hr. min.

9. Birthplace N.C. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Benj. McCarter
13. Birthplace N.C.

MOTHER 14. Maiden Name Elizabeth
15. Birthplace N.C.

16 (a) Informant Hezekiah Johns(H)
(b) Address 17 N.Norris St.

17 (a) Burial (b) Date thereof 6/1/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A.A.County, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N.Carrollton Ave

19 (a) Date received by registrar JUN 1 1947 (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/28/47 19 , at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 19 46, to May 28 19 47 and that I last saw her alive on May 27 1947.

Immediate cause of death	Duration
Coronary Insufficiency	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Milton Lesswick M. D.
Address 1429 W Fayette Date signed 5/31/47

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52216

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G52216 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city limits, write RURAL and give town)
(d) Street No. 911 Channey Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HYMAN FELDSTIEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Rebecca

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 66 Months Days If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Cleaner + Dyer

11. Industry or business

FATHER
12. Name Aaron
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Harry Feldstein
(b) Address 911 Channey Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-1-47 (month) (day) (year)
(c) Cemetery or crematory Hebrew Young Men
Location Windsor Mill Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 1429 E Balto St

19 (a) (b) Filed by registrar Washington Williams, M.D. Registrar

JUN 1 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/31 1947, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/27 1947 to 5/31 1947, and that I last saw h[illegible] alive on 5/31 1947.

Immediate cause of death	Duration
Intracerebral hemorrhage	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address [illegible] Date signed 5/31

X

G52217

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

G52217

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3220 W Garrison Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Frank

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Meyer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882 1884

8. AGE: Years 59 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Person
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Mrs J. Miller

(b) Address 3220 W Garrison Ave

17 (a) Burial (b) Date thereof 6-1-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Hebrew Mt. Carmel

18 (a) Funeral director Jack Kaiss & Son

(b) Address 459 E Balto St

1 19 1947 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/31 1947, at 4 15/4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/14 1947 to 5/31 1947 and that I last saw h[illegible] alive on 5/31 1947

Immediate cause of death Arteriosclerotic Heart Disease — Duration

Due to

Due to

Other Conditions A.S. Gangrene left foot Diabetes

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Perelman

Address Sinai Hospital Date signed 6/31/47

VS 150 Huntington Williams, Mgr. Baltimore, Md

93D

G52218

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 91a

G52218 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1100 N. Caroline Street
(c) Hospital or ~~INSTITUTION~~:
St. Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 26

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5720 Govane Avenue
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Brown, James D.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Separated

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 30, 1920

8. AGE: Years	Months	Days	If less than one day
26	6	27	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Sales Manager
11. Industry or business Balto. Marine Supply Co.

FATHER
12. Name Lester D. Brown
13. Birthplace Baltimore

MOTHER
14. Maiden Name Elizabeth Simpson
15. Birthplace Baltimore

16 (a) Informant Mrs. L. D. Brown
(b) Address 5728 Govane

17 (a) Burial (b) Date thereof 6/2/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Old Frederick Road

18 (a) Funeral director J. J. Foley's Sons
(b) Address 21 S. Eutaw St.

19 (a) (b) Washington, N.C.
(Date rec'd by registrar) Registrar

VS Form 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29, 1947, at 3:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 12, 1947, to May 29, 1947, and that I last saw him alive on May 29, 1947.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to	
Bacterial endocarditis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy: Aortic valvulitis, acute

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Anthony F. DiPaula, M. D.
Address St. Joseph's Hospital Date signed 6/3/47

X

G52219

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1860 (c)

Registered No. G52219

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age, is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert St.
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 506 Hanover St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Chew

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8 1873

8. AGE: Years	Months	Days	If less than one day
73	11	23	8 hr. 30 min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Thomas Chew
13. Birthplace Md.

MOTHER
14. Maiden Name Mollie Griffith
15. Birthplace Md

16 (a) Informant
(b) Address Roxbury

17 (a) (Burial, cremation, or removal) (b) Date thereof 6/3/47 (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director [illegible]
(b) Address [illegible]

19 6/1/47 (Date received by registrar) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 1947 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 27 1947 to May 31 1947, and that I last saw him alive on May 31 19

Immediate cause of death	Duration
(a) Hypostatic pneumonia	
Due to (b) Coxitis - Fracture Femur	
Due to (c) Probable Stroke	
Other Conditions Fracture of Right Femur (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation None
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 4/1
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 5-27-47 at 6 P.M.
(c) Where did injury occur? St. Paul Pl. nr. Pleasant St.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? public While at work? no
(Specify type of place) St. Paul Pl. nr. Pleasant St.
(e) Means of injury Fall down stairs or steps

23. Signature Laurence J. Knott M.D.
Address Mercy Hosp. Date signed 6-1-47
Howard Y. Williams, M.D.

G52220

BALTIMORE CITY HEALTH DEPARTMENT

CM 110944 CERTIFICATE OF DEATH ✓469

G52220 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 4 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give county)
(d) Street No. 1307 Wellsback Way--Overhill Heights
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilhelm Mary C.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Wid.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 12 1866

8. AGE: Years 80 | Months 9 | Days 18 | If less than one day hr. min.

9. Birthplace MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Stone (D)
13. Birthplace MD.

MOTHER 14. Maiden Name Mary (D)
15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern AVE.

17 (a) Burial (b) Date thereof 6/2/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Winter's Cem.
Location New Windsor Md

18 (a) Funeral director Wm Cook Inc
(b) Address 12178 Pulaski Highway

19 (a) JUN 2 1947 (Date rec'd by Registrar) (b) Emerting for Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30- 1947 19 47, at 1.20P M

21. I certify that death occurred on the date above stated; that I attended deceased from May -26 19 47, to May 30 - 19 47, and that I last saw her alive on May -30 19 47

Immediate cause of death: Uremia — Duration 10 hr.

Due to Carcinoma — Head of Pancreas ? — months

Due to

Other Conditions Jaundice

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Bruce Goodwin M. D.
Address Baltimore Md Date signed 3 June 47

X

G52221

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓830

G52221 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Home for Incurables
(b) Street address 700 W. 40th St.
(c) Hospital or institution: Home for Incurables
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr. 2mos
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Home for Incurables 700 W. 40th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marcus Llewellyn Bell

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9, 1883

8. AGE: Years	Months	Days	If less than one day
63	11	22	hr. min.

9. Birthplace Delhi, New York (Town, county, and state)
10. Usual Occupation Chemist
11. Industry or business

FATHER
12. Name George Bell
13. Birthplace New York

MOTHER
14. Maiden Name Stella Faisbee
15. Birthplace N.Y.

16 (a) Informant Home for Incurable Records
(b) Address 700 W. 40th St. M.7.16.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 6-5-47 (month) (day) (year)
(c) Cemetery or crematory Lane Hill Cem
Location Deposit N.Y.

18 (a) Funeral director Wm Cook Jno
(b) Address 1217 St Paul St

19 JUN - 2 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 1947, at 6:42 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 11 1946 to May 31 1947, and that I last saw him alive on 5/30 1947

Immediate cause of death: Cerebral Thrombosis — Duration: 3 Weeks
Due to: Arteriosclerosis (Generalized) — 2 1/2 Yrs.
Due to:
Other Conditions:
(Includes pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Grafton Derringer M.D.
Address 214 Medical Arts Bldg Date signed 6/31/47

G52222

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G52222

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 628 Eagu St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, strike RURAL and give name)
(d) Street No. 628 E Eagu St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Richard M Askew

3 (b) If veteran, name war
3 (c) Social Security Account No. 214-01-0849

4 Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Esther
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18, 1886

8. AGE: Years 60 | Months 8 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Sign Painter
11. Industry or business

FATHER 12. Name William Askew
FATHER 13. Birthplace Md
MOTHER 14. Maiden Name Indiana Williams
MOTHER 15. Birthplace Md

16 (a) Informant Esther Askew
(b) Address 628 E Eagu St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-3-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk. Location Baltimore Md

18 (a) Funeral director Gilmore & Son
(b) Address 1317 Park Ave

19 JUN - 2 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1947 at 2P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/4 1946 to 5/30 1947 and that I last saw h alive on 4/3 1947

Immediate cause of death	Duration
Coronary Thrombosis	15 mins
Due to Coronary Heart Disease	about 2 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis J. Kroll M. D.
Address 1801 Eutaw Place Date signed 5/30/47

G52223

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 94a

G52223 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16

(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3730 Edmondson ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George E. Wysong

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	married

6 (b) Name of husband or wife Mabel A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 13, 1873

8. AGE: Years	Months	Days	If less than one day
73	7	16	hr. min.

9. Birthplace W. Va.
(Town, county, and state)

10. Usual Occupation Printer

11. Industry or business

FATHER
12. Name John W. Wysong
13. Birthplace W. Va.

MOTHER
14. Maiden Name Nannie Shaw
15. Birthplace W. Va.

16 (a) Informant John T. Wysong
(b) Address 14 E. Eager St.

17 (a) Burial (b) Date thereof June 2/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Edgehill Charlestown W. Va.

18 (a) Funeral director Harry F. Wikle

(b) Address 4101 Edmondson Ave

19 JUN 2 - 1947 (b) Huntington W. Va. Registrar
(Date rec'd by Local Registrar) (Signature of Local Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-29 1947, at 4-45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-29 1947 to 5-29 1947 and that I last saw him alive on 5-29 1947.

Immediate cause of death Arteriosclerosis Heart Myocardial Infarction — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nathan B. Hyman

Address Sinai Hospital Date signed 5-29-47 M.D.

X

G52224

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

87c

G52224 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3338 Mount St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 333 S. Mount St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ellen Elizabeth Stone

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Henry B. Stone

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1877

8. AGE: Years: 69 | Months: 11 | Days | If less than one day: hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation H. W.

11. Industry or business

FATHER
12. Name Chas. D. Starle
13. Birthplace Md

MOTHER
14. Maiden Name Katherine E. Rush
15. Birthplace Md.

16 (a) Informant Henry B. Stone
(b) Address 333 S. Mount St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 2/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Rd

18 (a) Funeral director Harry H. Wittle
(b) Address 4101 Edmondson ave

19 JUN 2 - 1947 (Date rec'd by local reg.) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1947, at 1 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1946 to May 30 1947, and that I last saw h.. alive on May 29 1947

Immediate cause of death	Duration
Hypostatic pneumonia	
Due to Paralytic Ileus	
Due to Arthritis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Bulman M. D.
Address 203 Cathedral Date signed

VS 150

G52225

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G52225

BC# B-78727 157E

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or Institution: Emmanuel Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Hoyle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/19/47

8. AGE: Years	Months	Days	If less than one day
		8	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Harold W. Hoyle
13. Birthplace Md.

MOTHER
14. Maiden Name Patricia Paninski
15. Birthplace Germany

16 (a) Informant Harold W. Hoyle
(b) Address 1400 W. Fayette St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location [redacted] MAY 29 1947

18 (a) Funeral director [redacted] Commissioner of Health
(b) Address

19 (a) [redacted] 1947 Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/21/47 19 , at 1:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/14/47 19 , to 5/21/47 19 , and that I last saw him alive on 5/20/47 19 .

Immediate cause of death Atelectasis.

Due to Diaphragmatic hernia

Due to Congenital.

Other Conditions Dextrocardia
Transposition of Viscera
(Include pregnancy within 3 months of death)

Date of operation 5/20/47

Major findings of operation: Same as above

of autopsy: [illegible]

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. W. Stewart Jr.

Address Univ. Hosp. Date signed 5/21/47

G52226

BCH # 879621

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G52226
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave 16
(c) Hospital or institution: West Balto New Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 322 So Washington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Thomas Gebin Jr.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	infant

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25 - 1947

8. AGE: Years	Months	Days	If less than one day
		1	23 hr. 57 min.

9. Birthplace Balto Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Joseph J Gebin
13. Birthplace Balto Md -

MOTHER
14. Maiden Name Rose Paro
15. Birthplace Baltomd.

16 (a) Informant 322 So Washington
(b) Address Balto Md - St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School MAY 29 1947

18 (a) Funeral director Commissioner of Health
(b) Address
JUN 2 - 1947 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1947 at 1215 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/25/47 19 to 5/27/47 19, and that I last saw h[illegible] alive on 5/27/47 19

Immediate cause of death	Duration
a. Peritonitis	
Due to	
Due to	
Other Conditions Mother Rh neg Father Rh pos	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Grayson S. Waldrop
Address West Balt. Gen Hosp. Date signed 5/28/47 M.D.

VS 190

G52227

BALTIMORE CITY HEALTH DEPARTMENT

B# G79318 CERTIFICATE OF DEATH 159

G52227 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 day 18
(e) Length of stay in Baltimore (yrs., mos., or days) 4 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 242 N. Amity St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Merril Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29 1947

8. AGE: Years | Months | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Clifton Charles Nakell

13. Birthplace

MOTHER 14. Maiden Name Ernestine Thompson

15. Birthplace

16 (a) Informant Ernestine Thompson
(b) Address 242 N. Amity St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School MAY 29 1947

18 (a) Funeral director Commissioner of Health
(b) Address

JUN 2 - 1947 (State registrar) Hamilton Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1947, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 20 1947, to May 24 1947, and that I last saw him alive on May 24 1947

Immediate cause of death Atale tosis — Duration

Due to Prematurity 2 lb 6 oz Birth 25 weeks gestation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Milton Reisch M. D.

Address Redwood & Greene Sts Date signed 5/26/47

G52228

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G52228

MD# 478289 ✓ X 107

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt.
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 552 Carrollton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Clair Marbourger ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/12/47

8. AGE: Years	Months	Days	If less than one day
Hours		17	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Edwin Marbourger

13. Birthplace Md.

MOTHER 14. Maiden Name Virgilla Grant

15. Birthplace Maine

16 (a) Informant Virgilla Marbourger

(b) Address 552 Carrollton Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School MAY 29 1947

18 (a) Funeral director Commissioner of Health

(b) Address

19 JUN 2 - 1947 (Date filed by Registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-29-47 19 , at 9:54 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-28 19 47 to 5-29 19 47 and that I last saw h— alive on 5-29-19 47

Immediate cause of death Aspiration Pneumonia

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles H. Hawkins M.D.

Address University Hosp. Date signed 5-29-47

M. D.

X

G52229 **HEALTH DEPARTMENT—CITY OF BALTIMORE** G52229

DR# D19620

CERTIFICATE OF DEATH V 157E

1. PLACE OF DEATH Vol. of Amer. Hospt. Registered No.

CITY OF BALTIMORE: (No. 418 So. Lexington St. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. 1 da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME Boy Baby Miller

If U. S. Veteran specify WAR

(a) Residence: No. 440 Fawcett St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
M	W	

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) May 28 1947

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. —

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. —

10. Date deceased last worked at this occupation (month and year) — 11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore Md.

FATHER

13. NAME Leo Miller

14. BIRTHPLACE (city or town) (State or country) Balto Md.

MOTHER

15. MAIDEN NAME Rita Hood

16. BIRTHPLACE (city or town) (State or country) Balto Md.

17. INFORMANT Rita Miller

(Address) 440 Fawcett St.

18. BURIAL, CREMATION, OR REMOVAL

Place University Medical School MAY 29 1947 19

19. UNDERTAKER Commissioner of Health

(Address)

20. MAY 2 - 1947 Lexington Williams M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) May 28, 1947

22. I HEREBY CERTIFY, That I attended deceased from May 28, 1947 to May 28 1947

I last saw him alive on May 28, 1947 Death is said to have occurred on the date stated above, at 3:00 p.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Congenital Heart disease	5/28/47
Pneumonia	
Other contributory causes of importance:	

Was an operation performed? Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Leonard Gaynor M. D.

(Address) Volunteer by Emergency Hosp.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V9 8

X

C52230 TL - 110499

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V/86a

Registered No. C52230

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) 71 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 330 S. Robinson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Jane Flaherty or Mary June Flaherty

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 6, 1870

8. AGE: Years 76 | Months 6 | Days 5 | If less than one day ____ hr. ____ min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John O'Connor
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary O. Kayo
15. Birthplace Ireland

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/3/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto

18 (a) Funeral director Wm. Cook Jr.
(b) Address 217 St Paul St

19 JUN 2 - 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30, 1947, at 6.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 7 1947, to May 30 1947, and that I last saw h Of alive on May 30 1947

Immediate cause of death: Arteriosclerotic Heart Disease

Due to: Fracture neck of r. t. femur

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 5-15-47

Major findings of operation: Fracture neck of r. t. femur.

of autopsy:

Duration
23 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 1/2
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 5-7-47 at Homewood
(c) Where did injury occur? Baltimore (City or town) Md. (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? No
(e) Means of injury Fell while walking at home

23. Signature Maurice M. Day M. D.
Address Baltimore & Eutaw Sts. Date signed 6-1-47

To be approved by Medical Examiner
For S. Wm. S. Hilpert, by Howard J. Mueller, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

652231
47-110987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓47c

Registered No. 652231

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3hrs. 40min.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1512 E. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Estelia Edwards

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?-?

8. AGE: Years	Months	Days	If less than one day
55?	?	?	hr. min.

9. Birthplace ?
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 2, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cem
Location Brooklyn Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1701 Bridgeport Ave

19 (a) JUN 2 - 1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION pm

20. DATE OF DEATH May 27 1947, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-27 1947 to 5-27- 1947, and that I last saw h. alive on 5-27- 1947.

Immediate cause of death	Duration
Cardiac failure	
Due to	
Due to	over
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Doyle Waldron M.D.
Address B.C.H. Date signed 5-28-47

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52232

516 112.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G52232

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 55 N. Caroline St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Mattie Ware.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Sep.

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 2-2-00

8. AGE: Years 47. | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER 12. Name ? ?
13. Birthplace ?

MOTHER 14. Maiden Name ? ?
15. Birthplace ?

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 2, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cemetery
Location Baltimore Md

18 (a) Funeral director Elmer A. Wilson
(b) Address 1005 Busfotty and

19 (a)..... (b)..... (Date rec'd by registrar) Registrar

JUN 2 1947 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1947, at 6.20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 27 1947 to May 29 1947 and that I last saw her alive on May 29 1947

Immediate cause of death Haemorrhage from vessel of brain due to hypertension & arteriosclerosis

Due to with right hemiplegia — Duration: 4 days

Due to Hypertension Cardiovascular disease — Duration: 5-7 yrs

Other Conditions Obesity

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....
23. Signature Robert C. Austrian M.D.
Address John Hopkins Hosp Date signed 29 May 47

830

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52233

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G52233 Registered No. 1118

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3726 Chestnut Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, give township and R.F.D. number or name of incorporative town)
(d) Street No. 3726 Chestnut Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Birdie M. Fogle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	widow

6 (b) Name of husband or wife Guy Fogle.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 16, 1892

8. AGE: Years	Months	Days	If less than one day
54	9	14	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles E. Bagley
13. Birthplace Maryland

MOTHER
14. Maiden Name Amanda Fuhrman
15. Birthplace Maryland

16 (a) Informant Charles E. Fogle
(b) Address 3726 Chestnut Ave

17 (a) Burial (b) Date thereof June 2/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location

18 (a) Funeral director Edmund R. Donovan
(b) Address 3615-17 Chestnut Ave

19 (a) JUN 2 - 1947 (Date rec'd by registrar) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1947, at 10 15 M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Edema

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G. Pelfrey M.D.
Medical Examiner.
Date signed May 31, 1947

VS 151

G52234 CHERRY

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G52234

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1702 N Spring st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 35yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 727 N Bond (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Francis Cherry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife Samuel Cherrie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 20, 1877

8. AGE: Years	Months	Days	If less than one day
69 70	5	10	hr. min.

9. Birthplace Portsmouth Va (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Carter
13. Birthplace Va

MOTHER
14. Maiden Name Unknown
15. Birthplace unknown

16 (a) Informant Lovine Miller (daughter)
(b) Address 727 N Bond St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 2-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Baltimore - Md.

18 (a) Funeral director Mrs. Ida Bailey
(b) Address 1421 E. Jefferson St.

JUN 2 - 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1947, at 1 30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1946 to May 30 1947, and that I last saw h[illegible] alive on May 29 1947.

Immediate cause of death	Duration
Mitral Insufficiency	Couple yrs
Due to Rheumatic	
Due to	
Other Conditions Chronic Nephritis Hypertension, (arterio-sclerosis)	Couple yrs

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operations: —
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ralph Y. Mumma M.D.
Address 1424 E Monument St Date signed 5/31/47

92 B

G52235 CARRIGAN BALTIMORE CITY HEALTH DEPARTMENT G52235

CERTIFICATE OF DEATH 193

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland DOA
(b) Street address 1003 Keal Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1003 Keal Ct
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Neal Corrigan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Bessie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/23/15

8. AGE: Years 31 Months 8 Days 8 If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Riveter

11. Industry or business

FATHER
12. Name Andrew Carrigan
13. Birthplace Balto

MOTHER
14. Maiden Name Phoebe Hand
15. Birthplace Va.

16 (a) Informant Bessie Carrigan Wife
(b) Address 1003 Keil Court

17 (a) Burial (b) Date thereof 6/4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eagle Av

18 (a) Funeral director Sell & Zucker
(b) Address 403 S. Wolfe St

19 JUN 2 1947 Huntington Williams, M.D.
(Date rec'd by Reg.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/31 19 47, at 2:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fourth degree burns

Due to Electrocution

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5/31/47 at about 2:15 P.M.
(b) Where did injury occur? Vicinity 1003 Keal Ct.
(c) Did injury occur at home, on farm, industrial place, in public place? In front of home While at work? No
(d) Means of injury Flying sparks from welding a ground wire with electric welding machine

23. Signature C.P. Fulbright M.D.
Medical Examiner.
Date signed 6/1/47

VS 181

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52236

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G52236 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1700 Madison Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1700 Madison Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maria B. Scott

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years	Months	Days	If less than one day
40			hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William Scott
13. Birthplace Va

MOTHER
14. Maiden Name Susie Burrell
15. Birthplace Va

16 (a) Informant Helen Scott
(b) Address 1700 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 2 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location A. A. Co. Md.

18 (a) Funeral director Robert E. Williams
(b) Address 1515 McCulloh St

19 JUN 2 - 1947 (b) Huntington Ave

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1947, at 11:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 27 to May 29 1947, and that I last saw him alive on May 28 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	5 days
Due to Hypertension Cardiovascular Renal Disease	
Due to	
Other Conditions Pulmonary Tuberculosis (Include pregnancy within 3 months of death)	15 months

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 803 N Fremont Ave Date signed June 2

VS 150

131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52237 DOA #B-79329

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1579

G52237 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Howard and Madison Sts.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County None
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1004 Compton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Cosgrove

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-25-47

8. AGE: Years	Months	Days	If less than one day
—	—	6	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John P. F. Cosgrove
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Lillian L. Brown
15. Birthplace Virginia

16 (a) Informant John P. F. Cosgrove
(b) Address 1004 Compton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-2-1947 (month) (day) (year)

(c) Cemetery or crematory Catholic
Location Baltimore, Md.

18 (a) Funeral director Flynn-Fleming
(b) Address 1476 Light St.

19 JUN 2 - 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-31 1947, at 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-28 1947, to 5-31 1947, and that I last saw h[illegible] alive on 5-31 1947.

Immediate cause of death	Duration
Cardiac failure	
Due to Sclerodermia and pneumonia	
Due to Infiltrating anus & rectum, post-operative,	
Other Conditions Congenital	

(Include pregnancy within 3 months of death)

Date of operation 5-28-47

Major findings of operation: Infiltrating anus & rectum

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Carlton Brumfield M. D.

Address Maryland General Hosp. Date signed 5-31-47

VS 150

G52238

AB-105661

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. G52238

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7mos- 0days

(e) Length of stay in Baltimore (yrs., mos., or days) 51yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1535 McKean Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY ELIZABETH WAGNER

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Frank F. Wagner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 18- 1889

8. AGE: Years	Months	Days	If less than one day
58	4	11	hr. min.

9. Birthplace Maryland (Baltimore) (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER — 12. Name Wesley Vance

FATHER — 13. Birthplace ~~Maryland~~ Oklahoma

MOTHER — 14. Maiden Name Rachel

MOTHER — 15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/2/47 (month) (day) (year)

(c) Cemetery or crematory Stone Chapel Cem.

Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Baltimore, Md.

19 (a) JUN 2 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29- 1947, at 3.20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-29- 1946 to 5-29- 1947 and that I last saw her alive on 5-29- 1947

Immediate cause of death	Duration
Bronchopneumonia	4 days
Due to Ag. Cell Carcinoma of Cervix & Metastasis	2yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation

of autopsy Co above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

Signature [illegible] M.D.

Address City Hall Date signed 5-30-47

G52239

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G52239

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1814 Thomas Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1814 Thomas Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM ABRAHAM MORROW, SR.

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Margaret C. Morrow
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 18, 1863

8. AGE: Years	Months	Days	If less than one day
84	1	12	hr. min.

9. Birthplace Penna. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Isaac Allen Morrow
13. Birthplace Unknown

MOTHER
14. Maiden Name Elizabeth -
15. Birthplace Unknown

16 (a) Informant Miss Anna E. Morrow, daughter
(b) Address 1814 Thomas Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/2/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 JUN 2 - 1947 (Date rec'd by Local Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30, 1947, at 6 38 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1947, to May 30 1947. and that I last saw h.. alive on May 30 1947

Immediate cause of death	Duration
Arteriosclerosis and apoplexy	
Due to Senility	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. Paul Byerly
Address 410 Medical Arts Bldg. Date signed 5/31/47

V S 150

M. Paul Byerly X

G52240

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G52240

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1402 Poplar Grove St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1402 Poplar Grove St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ina F. Riggin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Edgar B. Riggin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25, 1876

8. AGE: Years	Months	Days	If less than one day
71	0	5	hr. min.

9. Birthplace Princess Anne, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business -

FATHER
12. Name William C. Griffith
13. Birthplace Md.

MOTHER
14. Maiden Name Drucilla C. Clayville
15. Birthplace Md.

16 (a) Informant Miss Kathryn Riggin
(b) Address 1402 Poplar Grove St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/3/47 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge Cem.
Location Howard County, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUN 2 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1947, at 1205 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place or in public place? While at work?
(d) Means of injury

23. Signature William L. Holbrook M.D. Medical Examiner.
Date signed May 31, 1947

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52241

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G52241 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Hampnett Ave.
(c) Hospital or institution:
Pine Ridge Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 4703 Hampnett Ave.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) **FULL NAME** Margaret Weber

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NO

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Frederick J Weber
6 (c) If dead, give age 83 years

7. Birth date of deceased (mo., day, yr.) Dec. 2 1867

8. AGE: Years 79 (80) | Months 6 (5) | Days (22) 23 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name John C. Kohlhepp
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace Germany

16 (a) Informant Mr. Kohlhepp
(b) Address 3315 Roes Kemp Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/4/47 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore

18 (a) Funeral director George W. Little
(b) Address 2710 Edmondson Ave.

19 JUN 2 - 1947 (Date rec'd by registrar) (b) Registrar

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 1947, at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 12 1946, to Dec. 31 1947, and that I last saw h. alive on May 29 1947.

Immediate cause of death: Left cerebral hemorrhage — Duration 5 days
Due to Arteriosclerotic vessels
Due to Hypertension
Other Conditions Chronic arthritis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. V. Harbold
Address 4706 Harford Road Date signed 6/1/47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52242

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G52242

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Franklin Square Hosp. 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1521 Vine St. (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME NORMAN BUNN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	married

6 (b) Name of husband or wife Lucinda Mae Bunn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 2, 1889

8. AGE: Years	Months	Days	If less than one day
58	3	27	....hr. ....min.

9. Birthplace Washington, N. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name James Bunn.
13. Birthplace Washington, N. C.

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Lucinda Bunn.
(b) Address 1521 Vine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-2-1947. (month) (day) (year)
(c) Cemetery or crematory Int. Ambrose,
Location.....

18 (a) Funeral director Mr. Kates R. Williams
(b) Address 322 N. Schroeder St.

19 JUN 2 - 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29, 1947, at 10:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 5/29/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52243

BALTIMORE CITY HEALTH DEPARTMENT

Bl# B 79371 CERTIFICATE OF DEATH √159

Registered No. G52243

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert and Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALT. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2126 HERBERT ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LARRY MARZULLO

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 25-1947

8. AGE: Years	Months	Days	If less than one day
		6 DAYS.	hr. min.

9. Birthplace BALT., MD. (Town, county, and state)

10. Usual Occupation CHILD

11. Industry or business

FATHER
12. Name VINCENT MARZULLO
13. Birthplace BALT., MD.

MOTHER
14. Maiden Name ALMA ARBOGAST.
15. Birthplace BALT., MD.

16 (a) Informant Mr VINCENT MARZULLO
(b) Address 2126 Herbert ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-2-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location BALTO

18 (a) Funeral director L. J. RUCK
(b) Address 5305 HARFORD RD.

19 (a) JUN 2 - 1947 by the Registrar (b) Registrar Washington Millburn, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-31 1947, at 11:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-25 1947, to 5-31 1947, and that I last saw him alive on 5-31 1947.

Immediate cause of death	Duration
Respiratory Failure	
Due to Prematurity	
Due to	
Other Conditions Erythroblastosis Fetalis (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James A. Ross M. D.
Address Mercy Hospital Date signed 5-31-47

X

G52244

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

G52244 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution:
Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 44 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Balt
(c) City or town Balt
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4305 Walther Blvd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John R. Langrehr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife MAGDALENE Langrehr
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Nov. 29-1883

8. AGE: Years	Months	Days	If less than one day
63 64	6	2	hr. min.

9. Birthplace Balt. Md.
(Town, county, and state)
10. Usual Occupation Retired.
11. Industry or business

FATHER
12. Name Louis Langrehr
13. Birthplace Balt.

MOTHER
14. Maiden Name Anna Schucks
15. Birthplace Balt.

16 (a) Informant Mrs. Mc Langrehr
(b) Address 4305 Walther Blvd.

17 (a) Burial (b) Date thereof 6-4-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balt.
18 (a) Funeral director L. Ryck Stanford Rd.
(b) Address 5305
JUN 2 - 1947 (b)
(Date rec'd by registrar) (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/31 1947, at 6.55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-26 1947, to 5-31 1947, and that I last saw him alive on 5-31 1947.

Immediate cause of death Resp. Fail

	Duration
Due to Ca Lung. ?	
Due to Lung abscess ?	
Other Conditions Arterio-Hypertension ? (Include pregnancy within 3 months of death)	

Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Thomas B Linthicum M.D.
Address Mercy Hosp Date signed 5/31/47

Dr. Golley

C52245

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C52245

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5001 Arabia Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5001 Arabia Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA FEDER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20, 1897

8. AGE: Years	Months	Days	If less than one day
50	--	9	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER 12. Name Richard Feder
13. Birthplace ?

MOTHER 14. Maiden Name Pauline Thon
15. Birthplace ?

16 (a) Informant Mrs. Pauline Feder
(b) Address 5001 Arabia Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/2/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 (a) JUN 2 - 1947 (Date rec'd by registrar) Huntington Hilligoss Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29, 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/22 1947 to 5/29 1947 and that I last saw her alive on 5/29 1947

Immediate cause of death	Duration
Pneumonia with Effusion	3 weeks
Due to	
Due to	
Other Conditions Coronary Thrombosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Ryan W. Golley M. D.
Address 5103 Harford Rd. Date signed 6/4/47

VS 150

110 B

G52846 Anderson
3001 Shannon Drive

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH √83a

Registered No. G52246

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3315 Dudley Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3315 Dudley Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY (MOLLIE) SILBERZAHN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife John
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1, 1874

8. AGE: Years	Months	Days	If less than one day
72	8	0	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name William Hugel
13. Birthplace Germany

MOTHER
14. Maiden Name Emma Esherick
15. Birthplace Germany

16 (a) Informant Mrs. Myrtle Fischer
(b) Address 3310 [redacted] Dudley Avenue

17 (a) Burial (b) Date thereof 6/4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) JUN 2 - 1947
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1st, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 30 1947 to June 1 1947 and that I last saw h alive on June 1 1947

Immediate cause of death: Cerebral Hemorrhage — Duration 3 days
Due to Hypertension
Due to
Other Conditions Arterio-Sclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter A Anderson M. D.
Address 3001 Shannon Drive Date signed June 2-47

VS 190

G52247

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

Registered G52247

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 929 Bevan St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs.) mos., or days) 25

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto City (If outside city or town limits, write RURAL and give town)
(d) Street No. 929 Bevan St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Gertrude Williams

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/2/1882

8. AGE: Years 64 | Months 5 | Days 27 | If less than one day hr. min.

9. Birthplace Westpoint Va (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Pohontas Davis
13. Birthplace Va

MOTHER
14. Maiden Name Rosie A Bray
15. Birthplace Va

16 (a) Informant Mary Davis
(b) Address 929 Bevan St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/2/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balt City

18 (a) Funeral director Hazel L Brown
(b) Address 108 W Montgomery St

19 JUN 2 - 1947 (Date rec'd by registrar) (b) Huntington for Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/29/47 19 , at 9P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 19 47 to May 29 19 47 and that I last saw h alive on May 29 19 47

Immediate cause of death

Due to Apoplexy

Due to Hemiplegia-Nov 1946

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
30d
1yr

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo Colyn Shelton M.D.
Address 905 S. Eaton Date signed 6/2/47

Balto-30, Md. X

G52248

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G52248 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1302 W. Lexinton St
(c) Hospital or institution: Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1302 W. Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lousia L. Diskin

3 (b) If veteran, name war: ##
3 (c) Social Security Account No. ##

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife ## Thomas Diskin (DISKIN)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: Abt 81 | Months | Days | If less than one day: hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name ? Laurent
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace France

16 (a) Informant Nora Miller
(b) Address 608 E. Fort Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/3/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Road

18 (a) Funeral director John J. Fahey & Sons
(b) Address 1318 Light St

JUN 2 - 1947 (Date filed by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/29 1947, at 11 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to May 29 1947, and that I last saw h[illegible] alive on May 29 1947.

Immediate cause of death: General arteriosclerosis Interstitial Chronic myocarditis — Duration: 5 yrs / 5 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nelson F. Solomon M.D.
Address 129 E Preston Date signed 5/31/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G52249

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

G52249
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2244 Fleet St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2244 Fleet St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Anna Filipiak (Phillips)

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-05-1992

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Joseph

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 11-1921

8. AGE: Years 26 | Months 2 | Days 20 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Felix Jaromin
13. Birthplace Poland

MOTHER
14. Maiden Name Anna Bruchowski
15. Birthplace Poland

16 (a) Informant Joseph Filipiak
(b) Address 2244 Fleet St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-4-47 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary
Location Balto. co. Md.

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern Ave

19 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 1947 at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1947 to May 31 1947 and that I last saw h[illegible] alive on May 31 1947.

Immediate cause of death: Tuberculosis Laryngeal — Duration 2 mos

Due to: Pulmonary T.B. — Duration 8 yrs

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 209 W. Pratt St. Date signed 6/4/47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52250

BALTIMORE CITY HEALTH DEPARTMENT X G52250 Registered No.

CERTIFICATE OF DEATH 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.O.A.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Rural - Taney Town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 11 Fairview Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edgar H. Essig

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Minnie E. Essig
Apr 13 - 91 6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
56	5	8	hr. min.

9. Birthplace Carroll Co. Md (Town, county, and state)
10. Usual Occupation Produce Dealer
11. Industry or business

FATHER
12. Name David Henry Essig
13. Birthplace Carroll Co. Md

MOTHER
14. Maiden Name Lucie Hahnenkamp
15. Birthplace Taneytown Md Carroll Co.

16 (a) Informant Minnie E. Essig
(b) Address Taneytown Md

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 6-2-47 (month) (day) (year)
(c) Cemetery or crematory Reformed Cemetery
Location Taneytown, Md

18 (a) Funeral director Raymond K. Wright
(b) Address Union Bridge Md.

6-2-1947 (b) Huntingtown Calvert, Md
(Date rec'd by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/31 1947, at 11 55 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 6/2/47

G52251 G52251

AB-108956

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1313

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mos- 22days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1815 W. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Irvin Edmonds

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30- 1925

8. AGE: Years	Months	Days	If less than one day
21	11	29	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Isaac Edmonds
13. Birthplace Maryland

MOTHER
14. Maiden Name Edith Grinnell
15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/2/47 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Pk
Location Balto County Md

18 (a) Funeral director Chas Harper
(b) Address 512 N. Carrollton Ave.

19 (a) 1947 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29- 1947, at 5.10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-7- 1947, to 5-29 1947, and that I last saw h[illegible] alive on 5-29- 1947

Immediate cause of death: Pulmonary Tuberculosis, Far. advanced — Duration: 14 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Refused

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Hunt
Address Balt. City Hosp. Date signed M. 5 D. 29 47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G52252

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G52252
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 191
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Same as
(a) State Md. (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 33 N. Mount St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM SMITH

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/7/1908

8. AGE: Years	Months	Days	If less than one day
✓ 40	10	22	hr. min.

9. Birthplace N.C.
(Town, county, and state)
10. Usual Occupation Contractor
11. Industry or business

FATHER
12. Name Joseph Smith
13. Birthplace Hope Mills, N.C.

MOTHER
14. Maiden Name Cornelius McNeal
15. Birthplace Hope Mills, N.C.

16 (a) Informant Jesse Smith (Bro).
(b) Address 33 N.Mount St

17 (a) Burial (b) Date thereof 6/4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory MT. Auburn Cem
Location Balto. Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave

19 (a) 1947 (b)
(Date filed by registrar)

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29, 1947, at 6.10a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
LOBAR PNEUMONIA

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D.
Medical Examiner
Date signed 5-29-47

VS 191

G52253

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V94a

G52253 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 208 Do Lloyd St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 208 Do Lloyd St (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Abraham Sody

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
64			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Confectionery Store
11. Industry or business

FATHER
12. Name Samuel
13. Birthplace Russia

MOTHER
14. Maiden Name Anna
15. Birthplace Russia

16 (a) Informant Wife
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-2-47 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Fernwood Md Rt

18 (a) Funeral director Paul Deuz Inc
(b) Address 1439 E. Balto St.

19 (a) (Signature of registrar) Huntington Williams M.D. Registrar
(Date received by registrar) JUN 2 - 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 1947, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 28 1947 to June 1 1947 and that I last saw h[illegible] alive on June 1 1947.

Immediate cause of death Coronary Thrombosis

Due to

Due to

Other Conditions Emphysema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Schulman Schapiro M. D.
Address 2028 Eastern Ave. Date signed 6/2/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52254

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 147

Registered No. G52254

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7615 WILKENS AVE
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7615 WILKINS AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARIE L. TRIBBE

3 (b) If veteran, name war

3 (c) Social Security Account No. NONE

4 Sex FEMALE | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife WM E. Tribbe

6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) October 8-1909

8. AGE: Years 37 | Months 7 | Days 24 | If less than one day 3 hr. min.

9. Birthplace Balto md
(Town, county, and state)

10. Usual Occupation
11. Industry or business HOUSEWIFE

FATHER
12. Name BERNARD A. FOIT
13. Birthplace BALTO MD

MOTHER
14. Maiden Name LAVENIA STARKEY
15. Birthplace BALTO MD

16 (a) Informant WILLIAM E. TRIBBE
(b) Address 7615 WILKINS AVE

17 (a) BURIAL (b) Date thereof JUNE 4 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location Balto Md

18 (a) Funeral director B. M. Walter & Co
(b) Address Peath & Stricker Sts

19 JUN 2 1947 (b) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 1st 1947, at 2 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 7 1947 to June 1 1947 and that I last saw h. alive on June 1 1947.

Immediate cause of death Carcinoma of the Lung — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Manuel J. Stamler M. D.

Address 1945 W. Balto Date signed 6/1/47

C52255

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 125B

Registered No. C52255

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street
(c) Hospital or institution: City Morgue
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
Country France
(a) ~~State~~ (b) County Tuferieure
(c) City or town Petit Quevilly (Seine)
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rue Armand Carel
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME PAUL DANIEL MARIE CHALM

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12, 1903

8. AGE: Years	Months	Days	If less than one day
43	11	4	hr. min.

9. Birthplace Audierne France (town, county and state)
10. Usual Occupation Captain French
11. Industry or business Merchant Marine

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Laurent Pompet (French Consul)
(b) Address 607 Stewart Building Baltimore
17 (a) Removal (Burial, cremation, or removal) (b) Date thereof June 12-1947 (month) (day) (year)
(c) Cemetery or crematory Petit Quevilly
Location France
18 (a) Funeral director Burgan Funeral Home
(b) Address 3636 Falls Road
19 (a) JUN 2 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION A

20. DATE OF DEATH May 16 1947, at 10:45 M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: natural causes [X] accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute hepatitis
Jaundice
~~Cause~~ Edema of lungs
Coronary arteriosclerosis

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill, M.D.
Medical Examiner.
Date signed 5-16-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52256

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92E

Registered No. G52256

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2825 Reese Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2825 Reese Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LUCY BUNDY

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife William Bundy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22, 1882

8. AGE: Years	Months	Days	If less than one day
65	2	5	hr. min.

9. Birthplace Staunton, Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Bowers
13. Birthplace Staunton, Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace Va.

16 (a) Informant Mr. William Bundy
(b) Address 2825 Reese St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-3-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 JUN 2 - 1947 (Date rec'd by Registr.) Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30, 1947, at 2P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 19th. 1947 May 30th. 1947. and that I last saw her alive on May 29th. 1947

Immediate cause of death	Duration
Acute Cardiac Dilitation	Immediate
Due to Myocarditis & Endocarditis	5 mos.
Due to ----------	
Other Conditions ----------	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jas W Montgomery M.D.
Address 401 E. 25th. St. Date signed 5/31/47.

G52257 GROENINGER

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44B

Registered No. G52257

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 922 East Biddle St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 922 East Biddle St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Robert Groeninger

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife Feb 6 1885

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 6 1885

8. AGE: Years 62 | Months 3 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Credit Manager

11. Industry or business Muth Bros

FATHER 12. Name Geo. Jos. Groeninger

13. Birthplace Baltimore

MOTHER 14. Maiden Name Dorothea Kalchenstein

15. Birthplace Balto

16 (a) Informant John Groeninger

(b) Address 922 East Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 3 1947 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Baltimore

18 (a) Funeral director Peter Wiedefeld

(b) Address 920 East Biddle St

19 JUN 2 - 1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 1947, at 1 10 M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 13 1946 to May 31 1947, and that I last saw h[illegible] alive on May 30 1947.

Immediate cause of death Hodgkins Disease (Abdominal)

Due to

Due to

Other Conditions Marked anemia

(Include pregnancy within 3 months of death)

Date of operation June 2 - 1947

Major findings of operation: Abdominal glands enlarged (Hodgkins Disease)

of autopsy:

Duration: Jan 1947

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis H. Krimerman M. D.

Address 722 N. Kenwood Date signed June 7 1947

VS 150

722 N Kenwood Ave Dr Krimerman X

G52258 — Volume #8

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

Registered No. G52258

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street
(c) Hospital or institution: City Morgue 26-
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Found (b) County
(c) City or town Standard Oil Co Pier (If outside city or town, write RURAL and give town)
(d) Street No. # 1 Canton (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Unknown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
35 ?			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory PUBLIC CEMETERY MAY 26 1947

Location

18 (a) Funeral director Commissioner of Health

(b) Address

(c) JUN 2 1947 (Date received by registrar) Hinckley Jr Holtzman M.D. (Signature of registrar)

MEDICAL CERTIFICATION 45

20. DATE OF DEATH May 8, 1947, at 4 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, ~~Inspection~~ or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury Found 5-5-47 26/6 M.

(b) Where did injury occur? Found-Standard Oil Co. Pier #1 Canton, Md.

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? ?

(d) Means of injury Found drowned

23. Signature George L. Merrill M.D. Medical Examiner.

Date signed 5/9/47

VS 181

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52259

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93a

G52259 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 961 N. Chester St.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 961 N. Chester Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOSEPH VIKTOR

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Mary Kapralek Viktor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 30, 1864

8. AGE: Years	Months	Days	If less than one day
82	7	1	hr. min.

9. Birthplace Czechoslovakia (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Louis Viktor - Son
(b) Address 1639 N. Milton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/4/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Rd. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) (Date received by registrar) Huntington Williams, M.D. Registrar

JUN 2 - 1947

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MEDICAL CERTIFICATION

20. DATE OF DEATH 31 May 1947 at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 27 May 1947 to 31 May 1947 and that I last saw h. alive on 30 May 1947

Immediate cause of death	Duration
Myocarditis, Acute	
Due to Arteriosclerosis	5 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward Tomaszewski M. D.
Address 1613 N. Milton Ave Date signed June 1 1947

X

G52260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G52260 Registered No.

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 419 N. Lakewood Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 419 N. Lakewood Avenue (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES EDWARD LENTZ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Mary A. Brady
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24, 1872

8. AGE: Years	Months	Days	If less than one day
74	11	6	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired Police
11. Industry or business

FATHER 12. Name unknown
FATHER 13. Birthplace "
MOTHER 14. Maiden Name "
MOTHER 15. Birthplace "

16 (a) Informant Albert Lentz - son
(b) Address 601 N. Luzerne Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/3/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1947, at 2:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 1938 to May 30 1947 and that I last saw him alive on May 27 1947

Immediate cause of death: Coronary Thrombosis — Duration 1 Day.
Due to Cardio-Vascular Hypertensive disease — 9 years
Due to Arteriosclerosis — 9 years
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Michael J. Dausch M.D.
Address 1 W. Arunda Ave Date signed 5/30/47

VS 150

X

G52261 G52261

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3115 McElderry St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3115 McElderry St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME CATHERINE M. BURLIN

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-24-9860

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or ~~wife~~ Charles E. Burlin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 26, 1876

8. AGE: Years	Months	Days	If less than one day
70	6	5	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business High's Ice Cream Co.

FATHER
12. Name Thomas Ferris
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Anna Wilson
15. Birthplace New York City, N. Y.

16 (a) Informant Charles E. Burlin, Jr.
(b) Address 3115 McElderry St.,

17 (a) Burial (b) Date thereof 6/5/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~cemetery~~ New Cathedral
Location Old Frederick Rd. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison St.

19 (a) (b)
(Date received by registrar) Registrar

6 1947 Huntington Williams, M.D.

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MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 1947 at 9 55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/11 1943 to 6/1 1947 and that I last saw h~~er~~ alive on 6/1 1947

Immediate cause of death	Duration
Coronary artery disease	
Arteriosclerosis (generalized)	
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis F. Klaines M.D.
Address 2623 E. Monument Date signed 6/2/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52262

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G52262 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State N.C. (b) County Camden
(c) City or town Shiloh
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BEDIE CUTRELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE Years 54 | Months | Days | If less than one day hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER 12. Name Johnathen Cutrell
13. Birthplace N. C.

MOTHER 14. Maiden Name Lucretia Sawyer
15. Birthplace N. C.

16 (a) Informant Tobey-Berry & Lynch
(b) Address Elizabeth City, N C

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 4-47 (month) (day) (year)

(c) Cemetery or crematory Shiloh, N C
Location North Carolina Camden Co

18 (a) Funeral director Williams Cartwright
(b) Address 127 Du Vane Street Huntington West Virginia

19 (a) (Date rec'd by registrar) JUN 3 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/2 1947, at 1:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/24 1947 to 6/2 1947
and that I last saw her alive on 6/1 1947

Immediate cause of death Obstruction, b common bile duct — Duration

Due to Hepato renal syndrome

Due to Diabetes mellitus

Other Conditions

(Include pregnancy within 3 months of death.)

Date of operation 5/29 Anesthesia

Major findings of operation: Common duct to stomach

of autopsy: Pancreas Congenital Path. Pathology

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address Union Hosp Date signed 6/3/47

G52263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1220

G52263 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 306 W. Franklin St (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME Randle M. Belt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/17/89

8. AGE: Years 58 | Months | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore County (Town, county and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name J. Shugg Belt
13. Birthplace Md

MOTHER 14. Maiden Name Susan E. Poole
15. Birthplace Md

16 (a) Informant Frank M. Poole
(b) Address 223 W. Lexington

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/4/47 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Wilson Corse
(b) Address 1210 St Paul St

(a) Date rec'd by local registrar JUN 3 1947 (b) Huntington Williams M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH 1 June 1947, at 4:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12 May 1947 to 1 June 1947 and that I last saw h[illegible] alive on 1 June 1947.

Immediate cause of death: Cardio-Resp. failure — Duration

Due to: Chronic myocardial disease — Duration

Due to: Hypertension — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Bilateral hernia

of autopsy: Myocardial fibrosis

22. If death was due to external cause, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address [illegible] Date signed 6/2/47

PHYSICIAN — Underline the cause to which death should be charged statistically.

G52264

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1228

G52264 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dix
(c) Hospital or institution: Balto City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto City, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 2 Balto City Hospital Infirmary (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Matelis

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Victoria
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Lith. (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name ? Mateles
13. Birthplace Lith

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Victoria Mateles
(b) Address 1802 Morrell Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 4-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Belair Rd

18 (a) Funeral director Joseph Kaminskas
(b) Address 608 Washington Blvd

19 JUN 3 - 1947 (b) Huntington Williams M.D.
Signature of local registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH 5/31 1947, at 12:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Intestinal Obstruction

Due to Post Operative adhesions

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature R. J. Lubarski M.D.
Medical Examiner.
Date signed 6/2/47

X

G52265

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 164E

G52265 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 Week

2. USUAL RESIDENCE OF DECEASED:
(a) State Tenn. (b) County
(c) City or town Norris
(If outside city or town limits, write RURAL and give town)
(d) Street No. P O 398
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maurice Raymond Thompson

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No. ~

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Sophie Howard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 5 1888

8. AGE: Years 58 | Months 5 | Days 28 | If less than one day hr. min.

9. Birthplace Lexington Mass
(Town, county, and state)

10. Usual Occupation Chemist

11. Industry or business

FATHER
12. Name Thomas Thompson
13. Birthplace Lynn Mass

MOTHER
14. Maiden Name Kate Ellen Brown
15. Birthplace Stratford Ct.

16 (a) Informant Geo Thompson
(b) Address 3717 S. St N.W Wash. D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 4 1947 (month) (day) (year)

(c) Cemetery or crematory All Hallows Chapel
Location Sandgonville A.A.Co Md

18 (a) Funeral director Henry J. Finkenstein Inc
(b) Address McCulloh & Richmond Sts

JUN 3 — 1947 (a) (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2, 1947, at 10 A. M.

21. I certify that I took charge of the remains described above, held an Inspection and partial autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured skull
Crushed chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6/2/47 at 10:15 A. M.
(b) Where did injury occur Union Memorial Hosp. 33rd & Calvert Sts
(c) Did injury occur at home, on farm, industrial place, in public place? Hospital While at work? No
(d) Means of injury Jumped from 5th floor window

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 6/2/47

G52266

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G52266

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1827 Ramsey St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1827 Ramsey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella M. Gearhart

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife John R

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 5 1890

8. AGE: Years 56 | Months 5 | Days 28 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name James T. Jones
13. Birthplace —

MOTHER
14. Maiden Name Arietta Powell
15. Birthplace —

16 (a) Informant Mamie G. Dash
(b) Address 18 W Rangely St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof June 4-47 (month) (day) (year)
(c) Cemetery or crematory Balto National
Location Balto Md

18 (a) Funeral director Robt C & B. M. Walter
(b) Address Bath & Fremont Sts

JUN 3 1947 Date rec'd by Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7 1947 12 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1934 to May 27 1947, and that I last saw him alive on May 27 1947.

Immediate cause of death	Duration
Arteriosclerotic Cardio Vascular Disease	3
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury

23. Signature Carel Kosling
Address 1326 W Lombard St Date signed 6/7/47

X

G52267.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/31a

Registered No. G52267

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 109 S Regester
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 109 S. Regester (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Loskarn Sr

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Margaret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 22 1860

8. AGE: Years 87 | Months 2 | Days 8 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business Retired

FATHER 12. Name Michael

13. Birthplace Germany

MOTHER 14. Maiden Name Catherine Sattler

15. Birthplace Germany

16 (a) Informant George Loskarn Jr.

(b) Address ~~1838 E. Lombard St.~~ 109 S. Regester St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/3/47 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Rd.

18 (a) Funeral director M. W. E. Dippel's Sons

(b) Address Lombard & Fremont Sts.

JUN 3 1947 (a) Deputy registrar (b) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1947 at 8:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1930 to MAY 30 1947, and that I last saw him alive on MAY 30 1947

	Duration
Immediate cause of death: ARTERIOSCLEROSIS	3 YRS
Due to: CHR. INT. NEPH	3 YRS
Due to:	
Other Conditions: CANCER OF RECTUM DUE TO ARTERIOSCLEROSIS	3 YRS.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M.D.

Address 304 W. Redwood Date signed 5-31-47

X

G52268

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V22B

Registered No. G52268

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hosp. 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balt. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1015 Plum Alley (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lane Leon Davis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	B	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1926

8. AGE: Years	Months	Days	If less than one day
21			hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Abraham McKinley
13. Birthplace Va.

MOTHER
14. Maiden Name Sarah Davis
15. Birthplace Va.

16 (a) Informant Sarah Pinkett
(b) Address 1015 Plum Alley

17 (a) Removal (b) Date thereof 6-3-47 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory West Point-
Location Virginia

18 (a) Funeral director Isaac T. Brown
(b) Address 101 W Monument St.

19 Filed JUN 3 1947 (b) Registrar Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 1947 at 3:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 25, 1947 to June 1, 1947. and that I last saw her alive on June 1, 1947.

Immediate cause of death	Duration
Cardio-resp. failure	
Due to Tuberculosis, Focal disseminated.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy Tuberculosis - Focal Dis.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Emma A. Jennings M.D.
Address Univ. Hosp. Date signed 6/2/47

G52269

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 94a

G52269 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 315 St. Dunstans Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-12
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 315 St. Dunstans Road (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME CONRAD MAULER

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 216-14-1592

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: EmmaVirginia Spence
6 (c) If alive, give age – years

7. Birth date of deceased (mo., day, yr.) Nov. 19, 1864

8. AGE: Years 82 | Months 8 | Days 11 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Merchant

11. Industry or business Mauler Bros.

FATHER
12. Name Conrad Mauler
13. Birthplace Germany

MOTHER
14. Maiden Name ? Easter
15. Birthplace Maryland

16 (a) Informant Mr. Robert Mauler (Son)
(b) Address 315 St. Dunstans Rd. Balto. 1

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 3. 1947 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore Md.

18 (a) Funeral director HENRY SANDER & SONS. INC.
(b) Address Baltimore Md.

JUN 3 – 1947 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May. 30. 1947 at 5.30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1928 to May 30 1947 and that I last saw h[illegible] alive on May 30 1947.

	Duration
Immediate cause of death: acute myocardial infarction	2 hours
Due to [illegible] heart disease	10 years
Due to arteriosclerosis	
Other Conditions benign prostatic hypertrophy	2 years

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Randall Smith, Jr. M. D.
Address 1014 St. Paul St. Date signed June 3 1947

VS 190

X

G52270

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G52270 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2825 Erdman Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2825 Erdman Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE ADAM LINK

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Margaret Anne Link
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30, 1863

8. AGE: Years	Months	Days	If less than one day
83	11	1	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired Park Police
11. Industry or business

FATHER 12. Name Louis John Link
13. Birthplace Germany

MOTHER 14. Maiden Name Mary Anna Hessler
15. Birthplace Germany

16 (a) Informant Miss Margaret Link
(b) Address 2825 Erdman Ave.

17 (a) Burial (b) Date thereof 6/3/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 JUN 3 1947 (Signature) Registrar
(Registered by Registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1, 1947, at 12:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1923 to June 1 1947.
and that I last saw him alive on June 1 1947.

Immediate cause of death	Duration
Acute heart failure	24 hrs
Due to Arteriosclerotic Cardio-Vascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature G B Stevens
Address 3400 Erdman Ave Date signed 6/2/47

G52271

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G52271

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2240 N. Fulton Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2240 N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIAS F. TAYLOR

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Bertha G. Taylor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 18, 1879

8. AGE: Years	Months	Days	If less than one day
68	3	13	hr. min.

9. Birthplace Carroll Co., Md.
(Town, county, and state)
10. Usual Occupation Motorman
11. Industry or business Balto. Transit Co. Md.

FATHER
12. Name William Taylor
13. Birthplace Carroll Co., Md.

MOTHER
14. Maiden Name Frances Taylor
15. Birthplace Carroll Co., Md.

16 (a) Informant Mrs. Bertha G. Taylor
(b) Address 2240 N. Fulton Ave.

17 (a) Burial (b) Date thereof 6/3/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bethel
Location Carroll Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 JUN 3 - 1947 (b) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31, 1947 at 8:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 1941 to May 31 1947, and that I last saw him alive on May 26 1947.

Immediate cause of death	Duration
Coronary Occlusion	—
Hypertensive C-V disease	10 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Spearnger
Address 1428 Kingsway Rd. Date signed 6-2-47

Kingsway Rd. X

G52272

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. G52272

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1313 Ramblewood Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1313 Ramblewood Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: SAMUEL H. MURPHY

3 (b) If veteran, name war: none

3 (c) Social Security Account No.:

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Edna W. Murphy

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 23, 1886

8. AGE: Years: 60 | Months: 11 | Days: 8 | If less than one day: hr. min.

9. Birthplace: Moyer, Penna. (Town, county, and state)

10. Usual Occupation: Tool Foreman

11. Industry or business: Black & Decker

FATHER
12. Name: Samuel H. Murphy
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Naomi Hoffman
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mrs. Edna W. Murphy
(b) Address: 1313 Ramblewood Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/3/47 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 JUN 3 - 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/31/ 1947, at 2:00a M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1946 to May 30 1947. and that I last saw h alive on May 30 1947.

Immediate cause of death	Duration
Carcinoma Pancreas	[illegible]
Upper Abdomen.	
Due to Metastases, Liver,	
Spleen + Adrenals	
Due to Coronary Thrombosis	March 1946
Other Conditions Bronchial Pneumonia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. A. Darby M. D.
Address 17 Medical Arts Bldg Date signed 6/5/47

G52273

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V/94a

G52273 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4738 Old York Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) 10
(d) Street No. 4738 Old York Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLARENCE E. PARKS

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Nellie E. Parks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1878

8. AGE: Years 68 | Months 8 | Days 10 | If less than one day hr. min.

9. Birthplace Harmony, Va. (Town, county, and state)
10. Usual Occupation Carpenter - retired
11. Industry or business Elmer Runge

FATHER
12. Name William Parks
13. Birthplace unknown

MOTHER
14. Maiden Name Elvira J. Blake
15. Birthplace Virginia

16 (a) Informant Mrs. Nellie P. Frame
(b) Address 4738 Old York Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/4/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

(a) Date rec'd by Registrar JUN 3 - 1947 (b) Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2, 1947, at 12:02 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 10 Jan. 1947 to 2 June 1947 and that I last saw h[im] alive on 1 June 1947.

Immediate cause of death: Coronary thrombosis — Duration: 2 weeks
Due to: arteriosclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature Samuel Schaefer M.D.
Address 714 E. Preston Date signed 2 June 47

X

G52274 G52274

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 59a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1606 Linden Avenue
(c) Hospital or institution:
14-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1606 Linden Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BELLE WILSON SHERMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife John H. Sherman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 3, 1865

8. AGE: Years	Months	Days	If less than one day
82	3	29	hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Franklin Wilson
13. Birthplace Virginia

MOTHER
14. Maiden Name Elizabeth Hall
15. Birthplace Virginia

16 (a) Informant Mrs. Sadie S. Sendtner
(b) Address 1606 Linden Ave.

17 (a) Burial (b) Date thereof 6/4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 JUN 3 - 1947 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2, 1947 19 at 2:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 47 to May 19 47
and that I last saw h.i.t. alive on 5/24/ 19 47

Immediate cause of death	Duration
Coronary Disease	
Due to	
Due to	
Other Conditions Chronic Rheumatism Arthritis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James Knott
Address 1422 Park Ave. Date signed 6/2/47

Frankil X

G52275

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G52275 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1004 Hilaman Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: WALTER RUSSELL SPRIGLE

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: wh
6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 4, 1898

8. AGE: Years	Months	Days	If less than one day
48	7	17 27	hr. min.

9. Birthplace Carroll Co., Md.
(Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name John F. Sprigle
13. Birthplace Carroll Co., Md.

MOTHER
14. Maiden Name Alverta Taylor
15. Birthplace Carroll Co., Md.

16 (a) Informant Mr. Arthur E. Sprigle
(b) Address 1822 Moreland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/4/47 (month) (day) (year)
(c) Cemetery or crematory Lineboro
Location Carroll Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

JUN 3 - 1947 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-31- 1947, at 10 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-13- 1945 to 5-30-1947, and that I last saw h. alive on 5-30 1947

Immediate cause of death acute Myocardial insufficiency — Duration

Due to Chronic Pulmonale

Due to Pulm. fibrosis + emphysema Chronic bronchial asthma

Other Conditions Dead on arrival Chr. congestive heart failure
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Anderson

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Bertha Raber M. D.
Address Sinai Hospital Date signed 5-31-47

Howard J. Mullins, M.D.

G52276

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1310a

G52276 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3612 Milford Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3612 Milford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME REBECCA JONES

3 (b) If veteran, name war -
3 (c) Social Security Account No. -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife Joshua Jones
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1859

8. AGE: Years	Months	Days	If less than one day
88	0	17	hr. min.

9. Birthplace Cockeysville, Md.
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Simeon Perry
13. Birthplace --

MOTHER
14. Maiden Name Emiline Stewart
15. Birthplace --

16 (a) Informant Mr. Wm. J. Jones
(b) Address 3612 Milford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/4/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 JUN 3 - 1947 (b) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31, 1947, at 7:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1943, to May 31 1947 and that I last saw h e r alive on May 31 1947.

Immediate cause of death	Duration
Hypertensive cardio-Vascular Disease	10 yrs.
Due to	
Due to Generalized Arteriosclerosis	
Other Conditions None Diabetes	- 3 yrs?

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: -
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Earl J. Chambers M. D.
Address 4108 Liberty Hts. Date signed 6/3/47

Hamilton for Hollingsworth, M.D.

937

G52277

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 46E

Registered No. G52277

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1210 Hanover St
(c) Hospital or institution:
23
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1210 Hanover St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William C. Becker

3 (b) If veteran, name war —

3 (c) Social Security Account No. 218-05-5768

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Louise Seabold Becker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17-1874

8. AGE: Years 73 | Months 1 | Days 14 | If less than one day ____hr. ____min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Fireman (Retired)

11. Industry or business

FATHER
12. Name Emanuel C. Becker
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Bowers
15. Birthplace Baltimore

16 (a) Informant Edward Becker
(b) Address 1210 Hanover St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 4-47 (month) (day) (year)

(c) Cemetery or crematory Western Cemetery
Location Edmondson Ave.

18 (a) Funeral director Elizabeth Hartle Funeral
(b) Address 115 E. West St. Westminster, Md.

19 (a) [illegible] (Local registrar) Westminster, Md. (Location)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31, 1947, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/4 1947 to 5/31 1947 and that I last saw him alive on 5/31 1947

Immediate cause of death: Carcinoma of bowel with multiple metastases — Duration: 2

Due to:

Due to:

Other Conditions: Hypertensive cardiovascular disease — Duration: 2
(Include pregnancy within 3 months of death)

Date of operation 5/23/47

Major findings of operation: Carcinoma of cecum with multiple metastases

Date of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Becker

Address 1206 Hanover St. Date signed 6/4/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

G52278 G52278

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1731 Gough Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-2
(e) Length of stay in Baltimore (yrs., mos., or days) 68 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1731 Gough Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MICHAEL PEKAR

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Cecilia
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) May 28, 1874

8. AGE: Years	Months	Days	If less than one day
73	0	4	hr. min.

9. Birthplace Czechoslavakia (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Cetilia Pekar
(b) Address 1731 Gough Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 4 1947 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Road

18 (a) Funeral director M. J. Radonshitzky
(b) Address 1808 Eastern Avenue

19 (a) Date received JUN 3 1947 (b) by Registrar Washington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 1947 at 8:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1 1947 to June 4 1947.
and that I last saw him alive on June 4 1947.

Immediate cause of death	Duration
[redacted] Uraemia Coma	24 hrs
Due to Carcinoma of Bladder with metastasis	(Primary) 5 mos
Due to	?
Other Conditions Diabetes	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [redacted] M.D.
Address 2007 E. Fayette Date signed 6/3/47

C52279 (3)
25-116898

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓55B

Registered No. C52279

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County [redacted]
(c) City or town Baltimore
(If outside city limits write RURAL and give town) Crownsville State Hospital
(d) Street No. 411 N. Fremont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Cora Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Separated

6 (b) Name of husband or wife Willis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7- 1887 ?

8. AGE: Years	Months	Days	If less than one day
60 ?	2	25	hr. min.

9. Birthplace Maryland (Town, county, and State)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Thomas Brooks
13. Birthplace Md.

MOTHER
14. Maiden Name Eliza
15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-2-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 JUN 3 1947 (Date received by Registrar) Huntington Williams M.D. (Registrar)

V S 150

MEDICAL CERTIFICATION AM

20. DATE OF DEATH May 30 1947 at 12.40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-16- 1947 to 5-30 1947, and that I last saw h er alive on 5-30- 1947

Immediate cause of death: Pulmonary Embolism following Laparotomy

Due to Myosarcoma of soft tissues of left hip with metastases to lungs - widespread

Other Conditions Emaciation

(Include pregnancy within 3 months of death)

Date of operation 5-29-47

Major findings of operation: Myosarcoma of left hip

of autopsy: Above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Marvin M. Lacy M. D.
Address Baltimore City Hosp. Date signed 5-31-47

X

G52280

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ X 937

Registered No. G52280

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 Cold Spring Lane
(c) Hospital or institution: Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Fullerton, Maryland (If outside city or town limits, write RURAL and give town)
(d) Street No. Fitch Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME ANDREW GERMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 8th, 1863

8. AGE: Years	Months	Days	If less than one day
84	9	23	hr. min.

9. Birthplace Baltimore County, Md. (Town, county, and state)

10. Usual Occupation farm hand

11. Industry or business

FATHER
12. Name Joshua German
13. Birthplace Baltimore County, Md.

MOTHER
14. Maiden Name Julia Fowler
15. Birthplace Baltimore County, Md.

16 (a) Informant Mrs. Alma Burnett
(b) Address Long Green & Kane Roads

17 (a) burial (Burial, cremation, or removal) (b) Date thereof June 4th/47 (month) (day) (year)
(c) Cemetery or crematory Hiss Methodist
Location Harford Road

18 (a) Funeral director Lasaak Funeral Home
(b) Address 7401 Belair Road

JUN 3 1947 (Date rec'd by Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1st 1947, at 10 pM

21. I certify that death occurred on the date above stated; that I attended deceased from March 3 1947 to June 1 1947, and that I last saw h.IM alive on May 31 1947.

Immediate cause of death	Duration
(a) Pneumonia -	4 days
Due to (b) Arteriosclerotic Heart Disease.	15 yrs.
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Norman R Klinman M. D.
Address 3803 Edmondson Ave Date signed 6/2/47

X

G52281

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V.13 B

Registered No. G52281

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1702 E. Preston St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1702 E. Preston St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mildred L. Galbreath

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2. 1929

8. AGE: Years 17 | Months 11 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Daniel Galbreath
13. Birthplace N.C.

MOTHER
14. Maiden Name Ida Wade
15. Birthplace N.C.

16 (a) Informant Mrs Ida Bryant
(b) Address 1702 E. Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-4-47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location R. I. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E Preston St

19 (Date received by registrar) JUN 3 - 1947 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 19 47, at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 31 19 47 to June 1 19 47 and that I last saw h[illegible] alive on May 31 19 47.

Immediate cause of death: Pulmonary tuberculosis — Duration 6 mos?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. K. Gilpin M. D.
Address 1224 N. Carlton Date signed June 3 47

VS 150

G52282 (Pietrowin K)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 M

Registered No. G52282

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2640 Hudson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2640 Hudson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William J. Pietrowiak (Price)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24 1910

8. AGE: Years	Months	Days	If less than one day
36	11	8	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Coppersmith
11. Industry or business

FATHER
12. Name Martin Pietrowiak
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Frances Wesolowski
15. Birthplace Baltimore Md.

16 (a) Informant Frances Pietrowiak
(b) Address 2640 Hudson St.

17 (a) Burial (b) Date thereof 6/6/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Dundalk Ave

18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson St

19 JUN 3 - 1947 (Date rec'd by registrar) Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2, 1947, at 2:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 4 1947, to June 2, 1947, and that I last saw him alive on June 2, 1947.

Immediate cause of death
Carcinoma of Right Mediastinum
Carcinoma of Kidney Heart

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Andrew Hunsworth M. D.
Address 2529 Eutaw Date signed

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52283

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G52283

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 718 Bay St
(c) Hospital or institution:
13-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 718 Bay St (If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country

3 (a) FULL NAME Daisy F Baseman

3 (b) If veteran, name war

3 (c) Social Security Account No. –

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Geo H Baseman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 7 - 1884

8. AGE: Years 62 | Months 7 | Days 24 | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER 12. Name Wilburn C Goodman

13. Birthplace unknown

MOTHER 14. Maiden Name Alma Borden

15. Birthplace unknown

16 (a) Informant George H Baseman Son

(b) Address 718 Bay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-4-47 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Baltimore Md

18 (a) Funeral director Frank H Seitz

(b) Address 847 W 36 St

19 JUN 3 - 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-1 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945 to 6-1 1947.

And that I last saw h e v alive on 6-1 1947.

	Duration
Immediate cause of death Coronary Thrombosis	2 da
Due to Hypertension CVD	?
Due to	
Other Conditions Diabetes Mellitus	?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lawrence J Lamanna M. D.

Address 371 Talbot Rd Date signed 6-2-47

937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52284

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

Registered No. G52284

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2119 Druid Park Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-7
(e) Length of stay in Baltimore (yrs., mos., or days) 5-0 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 715 Berry St
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME William E Reeves

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband ~~or wife~~: Wallace H Reeves

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 3 - 1875

8. AGE: Years 72 | Months 3 | Days 29 | If less than one day ..... hr. ..... min.

9. Birthplace (Town, county, and State)

10. Usual Occupation House wife

11. Industry or business

FATHER 12. Name Thomas Collins
13. Birthplace unknown

MOTHER 14. Maiden Name Sarah E Smith
15. Birthplace unknown

16 (a) Informant Wallace H. Reeves
(b) Address 715 Berry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6. 5. (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Baltimore Md

18 (a) Funeral director Frank J Belz
(b) Address 814 N 36 St

Date received JUN 3 1947 (b) Huntington Williamsport, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2, 1947, at 1.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 10, 1944 to June 2 1947; and that I last saw her alive on June 2 1947.

Immediate cause of death	Duration
Chronic Myocarditis	
Due to Artery Sclerosis	
Cardiovascular Renal Disease	
Due to	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louise C Wolfe M.D.
Address 1331 E Northave Date signed 6-2-47.

1310

G52285 B4 # 37394

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓186a

Registered No. G52285

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 5

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1115 McElderry st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SANDRA JEFFERSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 3-1945

8. AGE: Years	Months	Days	If less than one day
1 2	5	29	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Herman Jefferson
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mildred Wallace
15. Birthplace Baltimore Md

16 (a) Informant Mildred Jefferson
(b) Address 1115 McElderry St

17 (a) Burial (b) Date thereof June 5, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Brooklyn Md.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1009 Bentley ave

19 (a) JUN 3 - 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/1 1947, at 7:35 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured skull
Intracranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 5/2
(a) Date of injury 6/1/47 7 P.M.
(b) Where did injury occur? 1115 McElderry
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fell from 3rd floor window

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 6/2/47

VS 181

G52286

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V/22a

G52286 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 859 W. Franklin St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 859 W. Franklin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM P. JOHNSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Estelle Edwards Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 17, 1905

8. AGE: Years	Months	Days	If less than one day
42	3	13	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Laundryman
11. Industry or business

FATHER
12. Name George Johnson
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Maggie ?
15. Birthplace Virginia

16 (a) Informant Mrs Estelle E Johnson
(b) Address 859 W. Franklin Ste.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 6-5-1947 (month) (day) (year)
(c) Cemetery or crematory Northumberland Va
Location Virginia

18 (a) Funeral director Mrs Lottie R Williams
(b) Address 322 N. Schroeder St. Washington Nicholas Md

19 (a) 6611M-3 1947 (Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2, 1947, at 9.30 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Incarcerated right inguinal hernia, with intestinal obstruction, gangrene, and peritonitis.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 6-2-47

VS 181

652287

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

Registered No. 652287

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 762 W. Lexington St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Clegg (Clay)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Maggie Clegg

6 (c) If dead, give age years

7. Birth date of deceased (mo., day, yr.) March 25 1911.

8. AGE: Years	Months	Days	If less than one day
36	2	8	hr. min.

9. Birthplace Decatur, Ga.
(Town, county and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Oscar Clegg
13. Birthplace Decatur, Ga.

MOTHER
14. Maiden Name Lula Gray
15. Birthplace Decatur, Ga.

16 (a) Informant Maggie Clegg
(b) Address 762 W. Lexington St

17 (a) Shipped to (Burial, cremation, or removal) (b) Date thereof 6-6-1947 (month) (day) (year)

(c) Cemetery or crematory Decatur, Ga.
Location Atlanta, Ga.

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 323 E. Lenox Ave

19 (a) JUN 3 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 1947, at 1:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Jun death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Subarachnoid hemorrhage
(spontaneous)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L. Clegg M.D.
Medical Examiner

Date signed 6-3-47

VS 151

Nedwell

The G52288

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47a

Registered No. G52288

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1405 W. Fayette St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1405 W. Fayette St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frank D. Nedwell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary E. Nedwell
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) July 16 1885

8. AGE: Years	Months	Days	If less than one day
64	10	17	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Guard
11. Industry or business Social Security

FATHER
12. Name David Nedwell
13. Birthplace Md.

MOTHER
14. Maiden Name Lenora Hall
15. Birthplace Md.

16 (a) Informant Dr. David Thornton
(b) Address 1945 N. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-4-47 (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Baltimore

18 (a) Funeral director George A. Farley
(b) Address 1405 W. Fayette St.

19 JUN 3 - 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/2 1947, at 2 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from 5/1 1947 to 6/2 1947, and that I last saw h. alive on 6/2 1947.

Immediate cause of death CARCINOMA OF LARYNX — Duration 1 YEAR
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Manuel A. Thanadelis M. D.
Address 1946 W. Balto Date signed 6/2/47

VS 150

C52289

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No. C52289

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1316 Edison Highway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1316 Edison Highway
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Francesco S. Bianca

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Angelina
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6 1881

8. AGE: Years	Months	Days	If less than one day
65	11	25	hr. min.

9. Birthplace Cefalu Palermo Italy
(Town, county, and state)
10. Usual Occupation Saloon
11. Industry or business

FATHER
12. Name Salvatore Bianca
13. Birthplace Italy

MOTHER
14. Maiden Name Giovannina Giardina
15. Birthplace Italy

16 (a) Informant Angelina Bianca (Wife)
(b) Address 1316 Edison Highway

17 (a) Burial (b) Date thereof June 3rd/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.
18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.
19 JUN 2 - 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-31- 1947, at M
21. I certify that death occurred on the date above stated; that I attended deceased from 5-1- 1945 to 5-31- 1947, and that I last saw h. alive on 5-31- 1947.
Immediate cause of death Acute pulmonary Oedema. — Duration 2 days.
Due to organic Heart lesion + asthema — Duration several years.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature S. J. Emerick M. D.
Address Medical Arts Bldg Date signed 5/31/47

VS 150

C52290

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √46E

C52290 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4506 Frederick Ave
(c) Hospital or institution: Colonial Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give county)
(d) Street No. 4506 Frederick Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George A. Miller

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	widowed

6 (b) Name of husband or wife: Late Grace Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 17, 1872

8. AGE: Years	Months	Days	If less than one day
74	5	14	15 hr. min.

9. Birthplace Balto. Md
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Lawrence Miller
13. Birthplace Germany

MOTHER
14. Maiden Name —
15. Birthplace Germany

16 (a) Informant Carl F. Miller
(b) Address 905 Chestnut Hill Ave

17 (a) Burial (b) Date thereof 6/4/47.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Frederick Rd

18 (a) Funeral director Harry H. Mittle
(b) Address 4101 Edmondson Ave

19 (a) Date rec'd JUN 3 1947 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/1/47, 19, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1946 to June 1 1947, and that I last saw him alive on June 1 1947.

Immediate cause of death	Duration
(a) Asthenia Malnutrition	2 mo.
Due to (b) Carcinoma Asc. Colon	6 mo.
Due to (c) Hypostatic Pneumonia Cerebral accident (Hem	2 yrs. 8 mo.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Martin Jr. M.D.
Address 1433 W. Balto. St. Date signed 6/3/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G52291 Registered No. G52291

G52291

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St. & Linden Ave
(c) Hospital or institution: Maryland General Hospital 2?
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 74 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2853 W. Garrison Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mollie E. Walters

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife John L. Walters Sr.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7, 1873

8. AGE: Years 74 | Months 1 | Days 26 25 | If less than one day hr. min.

9. Birthplace Maryland (Town, county and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Samuel Seward (SEWARD)

13. Birthplace Maryland

MOTHER 14. Maiden Name Mary E. Dearborn

15. Birthplace Maryland

16 (a) Informant Howard W. Stem

(b) Address 3136 Belmont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-4-47 (month) (day) (year)

(c) Cemetery or crematory Sharpsville Cem

Location Sharpsville Md.

18 (a) Funeral director Layng Bros

(b) Address 5005 York Rd Govans

19 Date received JUN 3 1947 Wellington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 January 1947, at 1:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 26 May 1947 to 2 Jan 1947 and that I last saw her alive on 2 Jan 1947.

	Duration
Immediate cause of death Cardiac failure.	1 day
Due to Arteriosclerotic Heart Disease	15 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Allan Spicer

Address Md. Gen. Hosp. Date signed 2 Jan 47 D.

X

G52292

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G52292

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden + Meadeson Sts
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1034 N. Calvert St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harriet Riley

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife: John Riley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept 30 1884

8. AGE: Years	Months	Days	(If less than one day) hr.	min.
62	8	3		

9. Birthplace Macon Ga (Town, county, and state)
10. Usual Occupation Housemaid
11. Industry or business

FATHER
12. Name (Unknown) Moulton
13. Birthplace Ga

MOTHER
14. Maiden Name Rosa Boggs
15. Birthplace Ga

16 (a) Informant James A. Riley
(b) Address 5 Laurel Ave Huntington Sta

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-6-47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore Co Md

18 (a) Funeral director Wilhoyte Oak Sons
(b) Address 1217 S Paul St

19 (a) JUN 4 - 1947 (State registrar) (b) Huntington Williams Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3rd 1947, at 3:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 31st 1947 to June 3rd 1947, and that I last saw her alive on June 3rd 1947.

Immediate cause of death	Duration
Myocardial insufficiency	
Due to Pericarditis (purulent)	2 days
Due to Dehydration + Uremia	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Pericarditis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C.E. Gonzales
Address Maryland G. Hospital Date signed 6/3/47

X

G52293

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 54B

Registered No. G52293

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: UNIV. HOSPITAL.
(d) Length of stay in hospital or inst. (~~yrs., mos.,~~ or days) 31
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Pasadena P.O. (If outside city or town limits, write RURAL and give town)
(d) Street No. Riviera Beach (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BARBARA CURRAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Frank P. Curran
6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) Dec 30, 1873

8. AGE: Years	Months	Days	If less than one day
73	5	3	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER 12. Name ? Smith
13. Birthplace Germany

MOTHER 14. Maiden Name ? Hartzman
15. Birthplace Germany

16 (a) Informant Miss Lorette Curran
(b) Address Pasadena P.O. Riviera Beach

17 (a) Burial (b) Date thereof 6/8/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Annapolis Blvd

18 (a) Funeral director John F. Henry Inc
(b) Address 24 E. Eight St.

JUN 4 - 1947 (Date rec'd by Registrar) (b) Huntington Williamsville

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 JUNE 19 47 at 1'18 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 28 APR 19 47 to 2 JUNE 19 47 and that I last saw HER alive on 2 JUNE 19 47

Immediate cause of death	Duration
BRAIN TUMOR	
Due to METASTATIC - ?	
Due to Malignant	over
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 27 MAY 47
Major findings of operation: NONE
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Robert E. Brown M. D.
Address Univ. Hosp Date signed 2 June 47

X

G52294

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G52294

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 734 S. Bond Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Forrest Charles Thacker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1896

8. AGE: Years	Months	Days	If less than one day
50	8		hr. min.

9. Birthplace Barbersville W. Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James C. Thacker

13. Birthplace Unknown

MOTHER 14. Maiden Name Winnie Anderson

15. Birthplace Unknown

16 (a) Informant Mrs. W.E. Garnett Friend

(b) Address 4019 Sorcum St. Arlington Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 4-47 (month) (day) (year)

(c) Cemetery or crematory Arlington

Location Arlington Va.

18 (a) Funeral director Ellsworth Arrasco

(b) Address 3911 Liberty Heights Ave

19 (a) June 1947 (Date rec'd by Registrar) (b) Washington Williams M.D. Registrar

JON

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1947, at 7:00 A.M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Congestive heart failure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Earl L. Royer M.D. (Medical Examiner)

Date signed 5-27-47

G52295

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 74a

Registered No. G52295

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Prince Georges
(c) City or town Beltsville
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Ross

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Married

6 (b) Name of husband or wife Henrietta
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-13-90

8. AGE: Years	Months	Days	If less than one day
56 47	5	21	hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Harry Ross
13. Birthplace ?

MOTHER 14. Maiden Name Elizabeth Miller
15. Birthplace ?

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof June 6, 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Queens Chapel
Location Myrkerk Md

18 (a) Funeral director Henry S. Washington & Sons
(b) Address 467 N St NW. Wash. D.C.

JUN 4 - 1947 (b) Huntington Williams MD
(Date rec'd by local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1947 at 10:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 2 1947 to June 3 1947 and that I last saw h[illegible] alive on June 3 1947

Immediate cause of death	Duration
Lymphoid leukemia, generalized	15 Mos
Due to undetermined cause	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene Meyer M.D.
Address Johns Hopkins Hosp. Date signed June 3 1947

X

G52296

BALTIMORE CITY HEALTH DEPARTMENT

B 7th 68780 CERTIFICATE OF DEATH 119a

Registered No. G52296

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 114 N. Amity (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Isiah Seymore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 14, 1946.

8. AGE: Years	Months	Days	If less than one day
—	6 5	18	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER 12. Name James Seymore
13. Birthplace Va.

MOTHER 14. Maiden Name Nellie Venney
15. Birthplace Va.

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-4-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location.....

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 324 N. Schroeder St.

JUN 4 1947 (Date rec'd by Registrar) (b)..... Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 1947, at 9:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1947 to June 2 1947 and that I last saw him alive on June 2 1947.

Immediate cause of death ? Enterocolitis — Duration

Due to.....

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy: Cloudy swelling liver & kidneys

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature Barton Childs M. D.

Address Johns Hopkins Hosp Date signed 6-3-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G52297

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1178

G52297 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3014 Oakley Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isador Albert

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-26-7269

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Lena
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years	Months	Days	If less than one day
61	6		hr. min.

9. Birthplace Poland (Town, County, and state)
10. Usual Occupation Cashier
11. Industry or business

FATHER 12. Name unknown
13. Birthplace Poland

MOTHER 14. Maiden Name unknown
15. Birthplace Poland

16 (a) Informant Lena Albert
(b) Address 3014 Oakley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-4-47 (month) (day) (year)
(c) Cemetery or crematory Woodside
Location [illegible]

18 (a) Funeral director Leo Edelson Inc
(b) Address 1469 E Balto St

19 (a) JUN 4 1947 (Date rec'd) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1947, at 12:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 24 1947, to June 3 1947, and that I last saw him alive on June 3 1947.

Immediate cause of death	Duration
acute myocardial insufficiency and circulatory failure	
Due to hypertensive cardiovascular disease	old
Due to coronary occlusion	
Other Conditions ruptured duodenal ulcer	

(Include pregnancy within 3 months of death)
Date of operation June 3, 1947
Major findings of operation: ruptured ulcer
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 6-3-47 at 12 Noon
(c) Where did injury occur? Sinai Hospital (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Hospital While at work? No (Specify type of place)
(e) Means of injury: Died under Anesthetic: cyclopropane pentothal ether
23. Signature Allan H Mudd M.D.
Address [illegible] Date signed 6/3/47

Death cert. to be approved by Med. Examiner

G52298

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170C

Registered No. G52298

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 914 E. Pratt St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Ruth Gertrude Freno

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	widowed

6 (b) Name of husband or wife John Freno
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 11-1889

8. AGE: Years	Months	Days	If less than one day
57	5	21	hr. min.

9. Birthplace Indianna (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business —

FATHER
12. Name SALEM McCAIN
13. Birthplace ?

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace —

16 (a) Informant CHARLES J BAUMAN
(b) Address 1809 FLEET ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 6-7-1947 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location HARFORD RD.

18 (a) Funeral director Lilly V. Zeiler Inc.
(b) Address 403 S. Caroline St.

JUN 4 1947 (a) (Date received by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2, 1947 at 5:50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed Skull.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6/2/47 at 5:30 P.M. 3/2
(b) Where did injury occur? 800 Blk E. Pratt St
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Struck by truck Auto.

23. Signature [illegible] M.D. Medical Examiner
Date signed 6-3-47

VS 181

G52299

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G52299

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BARON RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4616 Belair Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4616 Belair Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lenna A Cain

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife John H Cain
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25 1864

8. AGE: Years 82 | Months 5 | Days 7 | If less than one day ____hr. ____min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER
12. Name Frederick John
13. Birthplace Germany

MOTHER
14. Maiden Name Don't Know
15. Birthplace Germany

16 (a) Informant Mrs Elsie Cain
(b) Address 4616 Belair Road

17 (a) Burial (b) Date thereof June 5
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Olivet Cem
Location Balto

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) (Date received by registrar) JUN 4 1947 (b) Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 1947, at 7.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 21 1947 to June 2 1947 and that I last saw h[illegible] alive on Jan 7 1947

Immediate cause of death Terminal Pneumonia — Duration 2 Days
Due to Hypostatic Congestion
Due to Chronic myocarditis
Due to Chronic Nephritis
Other Conditions Arteriosclerosis
Senility
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hester A Anderson M. D.
Address 300 Shawan Rd Date signed June 3-47

G52300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 19B

✓ G52300 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert - Saratoga
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4 N. Front St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert F. Burnett

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife ✓

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/17/1901

8. AGE: Years 46 | Months 1 | Days 14 | If less than one day hr. 15 min.

9. Birthplace Balto, Md. (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Retired

FATHER 12. Name Robert Burnett

13. Birthplace W. Va.

MOTHER 14. Maiden Name Frances Kattenhorn

15. Birthplace Balto, Md.

16 (a) Informant Mrs. Nicholas L. Lasley

(b) Address 1745 E. Chase St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/5/47 (month) (day) (year)

(c) Cemetery or crematory Lorraine

Location 5602 Dogwood Rd.

18 (a) Funeral director John F. Cowan & Son

(b) Address 901-03 Hollins St

19 JUN 4 1947 (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/2 1947 at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/29 1947 to 6/2 1947 and that I last saw h[illegible] alive on 6/2/1947

Immediate cause of death: Respiratory failure — Duration

Due to Pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard H. Sigler M.D.

Address Mercy Hospital Date signed 6/2/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ G52301 X 83a

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood & Greene St.

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4½ hrs.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County A. A. Co.

(c) City or town Arnold

(If outside city or town limits, write RURAL and give town)

(d) Street No. Peninsula Farm

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME GUSTAV F. Sanderson.

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	216-07-8821

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	Married

6 (b) Name of husband or wife Lillie S. Sanderson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/18/1899

8. AGE: Years	Months	Days	If less than one day
47	8	15	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Lawyer

11. Industry or business

FATHER

12. Name Shirley P. Sanderson

13. Birthplace Maine

MOTHER

14. Maiden Name Bertha Fredericks

15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Lillie S. Sanderson

(b) Address Peninsula Farm, Arnold, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/5/47 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

JUN 4 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1947, at 12 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1947 to June 3 1947 and that I last saw h. l. M. alive on June 3 1947.

Immediate cause of death: Cerebral hemorrhage left hemisphere — Duration: 6 hrs

Due to: Hypertension.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Gerald A. Meerten M. D.

Address Univ. Hospital Date signed 6-3-47

X .

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52302

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G52302 Registered No. 937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3822 Beech Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 week

2. USUAL RESIDENCE OF DECEASED:
(a) State California (b) County
(c) City or town San Francisco.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1925 Pierce St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harriet R. Davis

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widow

6 (b) Name of husband or wife Charles A. Davis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 25, 1883

8. AGE: Years	Months	Days	If less than one day
64	3	7	hr. min.

9. Birthplace Lititz, Lancaster Co., Pa.
(Town, county, and state)
10. Usual Occupation Veterans Administration
11. Industry or business U. S. Government

FATHER
12. Name Jacob W. Hollinger
13. Birthplace Pa/

MOTHER
14. Maiden Name Mary J. Carnes
15. Birthplace Magnolia, Balto. Co., Md.

16 (a) Informant Mr. John McFaul, Jr.
(b) Address 3822 Beech Ave.

17 (a) Burial (b) Date thereof 6/5/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 1947 (b) Huntington Hollinger, M.D.
(Date rec'd by registrar) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2nd 1947, at 6:30 P M

21. I certify that I took charge of the remains described above, held an Aug 5 Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G Hellrich M.D.
Medical Examiner.
Date signed June 3rd 1947

G52303

BALTIMORE CITY HEALTH DEPARTMENT ✓ G52303 Registered No.

CERTIFICATE OF DEATH 178X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 50 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 1212 McCulloh Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clara Glen GILLIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 9, 1924

8. AGE: Years 22 | Months 9 | Days 24 | If less than one day hr. min.

9. Birthplace Aberdeen, N.C. (Town, county, and state)

10. Usual Occupation Waitress

11. Industry or business

FATHER
12. Name Lee Gillis
13. Birthplace Richmond, Va

MOTHER
14. Maiden Name Lillie Douglas
15. Birthplace Aberdeen, N.C.

16 (a) Informant Miss Lillian Gillis
(b) Address 1212 N. Culloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 4, 1947 (month) (day) (year)
(c) Cemetery or crematory Family Lot
Location Aberdeen, N.C.

18 (a) Funeral director Wm. George H. Holland
(b) Address 631 Orchard Hill Ave

(a) JUN 4 1947 (Local registrar) Hunter Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2, 1947, at 7:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fluoride poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6/3/47 at 6 P.M.
(b) Where did injury occur? 1212 N. Culloh St Balto
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Ingestion of Poison

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 6/3/47

VS 191

X

G52304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93)

Registered No. G52304

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 625 WEST LANVALE STREET.
(c) Hospital or institution: NONE
(d) Length of stay in hospital or inst. (yrs., mos., or days) NONE
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY (If outside city or town limits, write RURAL and give town)
(d) Street No. 625 LANVALE STREET. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN EWELL.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Belle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1886

8. AGE: Years 60 | Months 9 | Days 21 | If less than one day hr. min.

9. Birthplace Accomac Co. Va (Town, county, and state)

10. Usual Occupation Insurance agent

11. Industry or business

FATHER
12. Name John O. Ewell
13. Birthplace Virginia

MOTHER
14. Maiden Name Ellen L. Hatton
15. Birthplace Virginia

16 (a) Informant Mrs Belle Ewell
(b) Address 625 N. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 5, 1947 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md

18 (a) Funeral director George H. Hoffman
(b) Address 1631 Druid Hill Ave

19 (a) (Date rec'd by registrar) (Signature of Registrar)

JUN 4 - 1947

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH MAY 31 1947 19 at 12.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from MAY 13 19 47 to MAY 31 1947 and that I last saw him alive on MAY 29 19 47

Immediate cause of death	Duration
CHRONIC MYOCARDITIS MAY 13	1947.
Due to ARTERIOR SCLEROSIS	1947
Due to	
Other Conditions NONE	

(Include pregnancy within 3 months of death)

Date of operation NONE.

Major findings of operation: NONE

of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas F Chantler M.D.
Address 3013 ST PAUL STREET. Date signed MAY 31 1947.

G52305 BALTIMORE CITY HEALTH DEPARTMENT G52305
CERTIFICATE OF DEATH 937 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1826 E Lombard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1826 E Lombard St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alois Sittka
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Theresa
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 2 1868
8. AGE: Years 78 | Months 6 | Days 29 | If less than one day hr. min.
9. Birthplace: Austria (Town, county, and state)
10. Usual Occupation
11. Industry or business: Retired
FATHER 12. Name: Johann Sittka
13. Birthplace: Germany
MOTHER 14. Maiden Name: ?
15. Birthplace: Germany
16 (a) Informant: Louise Schram
(b) Address: 1826 E. Lombard St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/6/47 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Rd.
18 (a) Funeral director: M. W. E. Engel's Sons
(b) Address: 1611 Gard & Penn Sts.
19 (a) Dec 4 1947 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION
20. DATE OF DEATH June 1 1947, at 7:25 P.M
21. I certify that death occurred on the date above stated; that I attended deceased from May 1947 to June 1947 and that I last saw him alive on May 30 1947
Immediate cause of death: Coronary Thrombosis — Duration 2 hrs.
Due to: Arteriosclerotic Cardio-Renal Disease
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:
23. Signature: J. Harry Haas
Address: 4718 Hamilton Blvd. Date signed 6/3/47

V S 150

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G52306

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G52306 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 528 N.Washington St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 528 N Washington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace W.Deal

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Howard D.Deal
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb.10,1876

8. AGE: Years	Months	Days	If less than one day
71	3	22	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name James Mullen
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Margaret M.Adlet
15. Birthplace Balto. Md.

16 (a) Informant Howard D.Deal
(b) Address 528 N.Washington St.

17 (a) Burial (b) Date thereof June 5,1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St.Johns R.Cem.
Location Balto. Md.

18 (a) Funeral director Philip Herring Sons
(b) Address 2024 Orleans St.

19 (a) 1947 June 6 Huntington Williams Registrar
(Date) (month) (day) registered

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2,1947 19 at 11.20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from January 1937 to June 2 1947.
and that I last saw h alive on June 1947.

Immediate cause of death	Duration
Cerebral Hemmorhage	1 hr.
Due to Chronic Arteriosclerotic	
Due to Hypertension	10 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Francis J. Ayd M. D.
Address 2005 E. Monument St Date signed 6/4/47

VS 150

G52307

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G52307 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John's Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and name town)
(d) Street No. 434 N Eden St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Hamlet

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years 59 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Lynchburg Va
(Town, county, and state)

10. Usual Occupation Minister

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace "

MOTHER 14. Maiden Name Nancy Hamlett
15. Birthplace

16 (a) Informant Frank Brown
(b) Address 434 N. Eden St.

17 (a) Burial (b) Date thereof 6/4/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Lutherans Man. Pk.
Location

18 (a) Funeral director Elroy O Wilson
(b) Address 1000 Bfandt & Ave

19 (a) (Date rec'd by registrar) JUN 4 1947 (b) Huntington-Williams, Md

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1st 1947, at 10:45 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. McGlone M.D.
Medical Examiner
Date signed June 4 47

G52308

BALTIMORE CITY HEALTH DEPARTMENT ✓ G52308
CERTIFICATE OF DEATH 1316 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY—WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Providence Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1357 N. Gilmor St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Monzyn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day: hr.	min.
68				

9. Birthplace unknown (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name unknown
13. Birthplace " "

MOTHER
14. Maiden Name unknown
15. Birthplace " "

16 (a) Informant James Snowden
(b) Address 1357 N. Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 (Month) 7 (Day) 47 (Year)
(c) Cemetery or crematory Mt Calvery
Location

18 (a) Funeral director Elroy A. Wilson
(b) Address 1005 Brantly Ave,
JUN 4 — 1947 (Date rec'd by registrar) Huntingtown Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/31/47 19 at 5 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-30-47 19, to 5/31/47
and that I last saw h alive on 5-31-47

Immediate cause of death Acute Urinary retention — Duration

Due to Hypertrophy of Prostate Unknown

Due to

Other Conditions Pul-Chr. Nephritis

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. R. L. Jackson, M.D.
Address Provident Hosp. Date signed 6/1/47

VS 150

137a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52309

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 10

G52309 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 dys
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2606 Guilford
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Hedrick, Florence Spranklin

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25-1876

8. AGE: Years	Months	Days	If less than one day
71 72	2	9	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Spranklin
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name - Caroline Kuszmanl
15. Birthplace unknown

16 (a) Informant M.W. Hedrick
(b) Address Baltimore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 6 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Loudon Park
18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street
19 (a) (Date received by registrar) (b) June 4 1947 Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1947, at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 12 1947 to June 3 1947, and that I last saw her alive on June 3 1947

Immediate cause of death	Duration
Congestive Heart Failure	
Due to Diphtheria	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation May 14, 1947
Major findings of operation: Tracheotomy - done elsewhere
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Robinson M. D.
Address Sydenham Hosp. Date signed 6/3/47

X

G52310

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G52310 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1618 Belt St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1618 Belt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James E. Curran

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-1685

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife (Nee Luber) L. Adelaide Curran
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) January 28, 1887

8. AGE: Years	Months	Days	If less than one day
60	4	5 6	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation (LAST) Rigger
11. Industry or business (LAST) Md. Drydock Co.

FATHER
12. Name Cornelius O'Curran
13. Birthplace Missouri

MOTHER
14. Maiden Name Mary E. Scott
15. Birthplace Md.

16 (a) Informant Mrs. L. Adelaide Curran, Wife
(b) Address 1618 Belt St. Balto. 30, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 6, 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director R. Bernard Evans
(b) Address 1400 S. Charles St., Balto. 30, Md.

19 (a) JUN 4 1947 (Date received by registrar) Hattie Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1947, at 2:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-1, 1944 to 6-3 1947 and that I last saw him alive on 6-2 1947

Immediate cause of death	Duration
Coronary Thrombosis	1 Day
Due to Arteriosclerosis	3 Yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. A. Ballard M. D.
Address 707 Fort Ave. Date signed 6-3-47

V S 150

Dr. F. G52311

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G52311 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2209 Kirk Avenue
(c) Hospital or institution: 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2209 Kirk Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Edward Shannon

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years	Months	Days	If less than one day
43	—	1	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John T. Shannon
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Anna T Burke
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. John T Shannon
(b) Address 2209 Kirk Avenue

17 (a) Burial (b) Date thereof 6/4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location City

18 (a) Funeral director Wiedefeld & Son
(b) Address Greenmount Ave & 22nd St.

JUN 4 – 1947 Huntington Williams M.D.
(Date received) (Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2nd 1947, at 9.00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-1-47, to 6-1-47, and that I last saw h alive on 19

Immediate cause of death	Duration
Carcinoma of Stomach	3 yrs?
Due to	
Due to Metastic Granuloma	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. D. Flynn, M.D.
Address 11 E. Chase St Date signed 6-4-47

VS 150

G52312 JL - 57069

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G52312

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-11-1 22
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 529 S. Charles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Lee Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 4, 1864

8. AGE: Years 82 | Months 9 | Days 0 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Glass Blower

11. Industry or business

FATHER
12. Name Herman
13. Birthplace Germany

MOTHER
14. Maiden Name Martha Boyd
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/6/47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Wilson Cook Inc
(b) Address 1219 E. Lond St

19 (a) 6-5-1947 (Filed by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 1947, at 2.05AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 3 1940 to June 4 1947 and that I last saw h 1m alive on June 4 1947

Immediate cause of death	Duration
Coronary occlusion	2 days
Due to Arteriosclerotic cardio-vascular disease.	
Due to	
Other Conditions 1. Hemiplegia arteriosclerotic 2. Arteriosclerosis, right foot Sores. 3. Bedsore buttocks	

(Include pregnancy within 3 months of death)

Date of operation 4/11/47

Major findings of operation: Arteriosclerosis. 1st metatarsal, right foot.

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. A. Gibbs M.D.
Address Balti. City Hospitals Date signed 6/7/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52313

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G52313 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp. 126
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1213 S. Clinton Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Delmas (Belman) B. Jenkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3, 1947, at 10 07 P. M.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced
Male	White	Married

6 (b) Name of husband or wife Mildred Jenkins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 23rd 1909

8. AGE: Years	Months	Days	If less than one day
37	9	10	hr. min.

9. Birthplace Strasburg Va
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Bethlehem-Fairfield

FATHER
12. Name Edward Jackson
13. Birthplace Va

MOTHER
14. Maiden Name Mary S. ?
15. Birthplace Va.

16 (a) Informant Mildred Jenkins
(b) Address 1213 S. Clinton St.

17 (a) Burial (b) Date thereof 6/7/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) JUN 5 - 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed skull

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 24/2
(a) Date of injury 6/3/47 at 9.25 A. M.
(b) Where did injury occur? Key Highway (Beth. Steel Corp.)
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury fell from staging 40 ft to bottom of hatch

23. Signature Carl L. Von Glahn M.D.
Medical Examiner
Date signed 6/4/47

VS 181

G52314

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G52314
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Woodbrook - Govans
(If outside city or town limits, write RURAL and give town)
(d) Street No. Haddon & Bellona Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Whitney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widower

6 (b) Name of ~~husband or~~ wife: Emma D. Whitney

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-[illegible]-81

8. AGE: Years 65 | Months 8 | Days 8 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Civil Engineer

11. Industry or business

FATHER
12. Name William Whitney
13. Birthplace Md

MOTHER
14. Maiden Name Margaret Christ
15. Birthplace Balto. Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/7/47 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Moreland Park
Location Parkville, Md.

18 (a) Funeral director William Cook Inc
(address)

19 (a) JUN 5 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 19 47 at 8:45 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from May 13 19 47 to June 4 19 47 and that I last saw him alive on June 4 19 47

Immediate cause of death: Heart failure — Duration
Due to: Arteria sclerotic
Heart disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maurice B. Wurtzbach M. D.
Address J H H Date signed June 4 47

VS 150

G52315

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G52315

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 118 1/2 Aisquith St
(c) Hospital or institution: 5

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 118 1/2 Aisquith St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Max Aronson

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widow

6 (b) Name of husband or wife Dora

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years	Months	Days	If less than one day
81			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Isaac
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah
15. Birthplace Russia

16 (a) Informant M. Aronson — Son
(b) Address 118 1/2 Aisquith St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-5-47 (month) (day) (year)
(c) Cemetery or crematory Herring Run
Location Phil Rd & Bowleys Lane

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto St

19 (a) JUN 5 - 1947 (Date rec'd by registrar) Huntington Williams, M.D. (Registrar) (b) Address

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-3-1947, at 10:17 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1930, to June 3 1947, and that I last saw h[illegible] alive on June 3 1947

Immediate cause of death	Duration
Uremia	
Due to Hypertensive C.V. & Arteriosclerosis Contributory	
Due to	
Other Conditions Chr. Bronchitis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Morris A. Finn M. D.
Address 118 Aisquith St Date signed 6/4/47

VS 150

G52316

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

137a

Registered No. G52316

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 13-
(c) Hospital or institution: West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2502 Parkwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Max Leiderman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Leah Leiderman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25, 1876

8. AGE: Years	Months	Days	If less than one day
70	10	10	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Michael
13. Birthplace Poland

MOTHER
14. Maiden Name Mary
15. Birthplace Poland

16 (a) Informant Wife
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-5-47 (month) (day) (year)
(c) Cemetery or crematory Auf Chaim
Location Wash Blvd

18 (a) Funeral director Jack Lewis Inc.
(b) Address 1439 E. Baltimore St.

19 (a) JUN 5 - 1947 (Date rec'd by registrar) Huntington Millinocket, Me.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 1947, at 2:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 16 1947 to June 4 1947, and that I last saw h. alive on June 4 1947

Immediate cause of death	Duration
Cardiac Failure	
Due to Hypertensive Arterio-Sclerotic Heart Disease	
Due to	
Other Conditions Benign Prostatic Hypertrophy (Include pregnancy within 3 months of death)	

Date of operation June 3, 1947
Major findings of operation: Benign Prostatic Hypertrophy
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry T. Finger M. D.
Address West. Bal. Gen. Hosp. Date signed 6-4-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52317 Smutek

BALTIMORE CITY HEALTH DEPARTMENT

Bl# 081167 CERTIFICATE OF DEATH 159

Registered No. G52317

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Lyt. Street. (20)
(c) Hospital or institution: South Baltimore General Hosp. 2-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (30)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1622 Eastern Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Smutek.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 31 May 47.

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Martin Smutek.
13. Birthplace

MOTHER
14. Maiden Name Mary W. Brongowski
15. Birthplace Baltimore.

16 (a) Informant mother
(b) Address 1622 Eastern Ave.

17 (a) Burial **(b) Date thereof** 6-5-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto. Co.

18 (a) Funeral director Wm. B. Fralkowski
(b) Address 2007 Eastern ave

19 [illegible] by [illegible], Washington, Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 June 1947 9:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 21 May 1947 to 3 June 1947, and that I last saw h[illegible] alive on 2 June 1947.

Immediate cause of death	Duration
Respiratory failure.	
Due to Hemorrhage from gastroduodenal ulcer.	
Due to Pre-maturity & Abortion. Gravid 24 months.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Tyler M.D.

Address South Balto. Gen'l Hosp. **Date signed** 5 June 47

VS 150

G52318

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓97

Registered No. G52318

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4506 Frederick Ave
(c) Hospital or institution: Colonial Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 320 N. Monroe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David T. Zipsdorff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M.
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Agnes V.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Apr. 1 1867
8. AGE: Years 80 | Months 2 | Days 1 | If less than one day hr. min.
9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Clothing Salesman

FATHER
12. Name Tobias S. Zipsdorff
13. Birthplace Md

MOTHER
14. Maiden Name Susan Everhart
15. Birthplace Md.

16 (a) Informant A. M. Anderson
(b) Address 13 W. Franklin St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/5/47 (month) (day) (year)
(c) Cemetery or crematory Western Lot Edmondson Ave. & Longwood St.
18 (a) Funeral director Henry H. Eutaw
(b) Address 1947 Edmondson Ave
19 JUN 5 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/2/47. 19 , at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-2 1947, to 6-2 1947, and that I last saw h. alive on 6-2 1947

	Duration
Immediate cause of death: Cardiac failure	3 days
Due to: Arteriosclerosis	yrs
Due to: Hypertension	year
	3 Mos
Other Conditions: Senile Dementia	yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
D. Signature Wilbur L. Feeney M. D.
Address 3025 Belair Rd Date signed 6-4-47

VS 150

X

G52319

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

Registration No. G52319

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1901 h Patterson Park Avenue

(c) Hospital or institution:

8-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 47 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1901 h Patterson Park Avenue
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Lind

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex: male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Catherine Lind

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 3, 1899

8. AGE: Years 48 | Months 4 | Days 0 | If less than one day: hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation Brass manufacturer

11. Industry or business Tar Gulf

FATHER

12. Name Conrad Lind Sr

13. Birthplace Baltimore Md

MOTHER

14. Maiden Name Dora Mallon

15. Birthplace Baltimore Md

16 (a) Informant Mrs Ralph Hartzgen

(b) Address 1905 h Patterson Pk Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 6, 1947 (month) (day) (year)

(c) Cemetery or crematory Parkwood Cemetery

Location Taylor Avenue

18 (a) Funeral director J Albert L Hilz Jr

(b) Address 1936 h Chester Street

19 (Date received by registrar) JUN 5 - 1947 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1947, at 2.20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 7 1947 to June 3 1947 and that I last saw him alive on June 3 1947.

Immediate cause of death Cardiac Decompensation — Duration 2 days

Due to Myocardial Insufficiency — Duration 2 months

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Albert Greenberg

Address 1025 E North Ave Date signed 6/5/47

VS 190

B52320

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G52320

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3538 White Chapel Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-11
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or incorporate limits, write RURAL and the town)
(d) Street No. 3538 White Chapel Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel Berger

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Rachel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 72 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (City, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER 12. Name Morton
13. Birthplace Russia
MOTHER 14. Maiden Name Leah
15. Birthplace Russia

16 (a) Informant Wm Berger
(b) Address 3538 White Chapel Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-5-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1429 E Balto St Baltimore, Md

JUN 5 - 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

19. DATE OF DEATH 6-4- 1947, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1945 to 6/4 1947 and that I last saw alive on

Immediate cause of death: Coronary Occlusion — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. Childers M.D.
Address 2225 Linden Ave Date signed

VS 150

G52321

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 48 B

Registered No. G52321

PLEASE WRITE PLAINLY, WITH UNFADING INK. MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 265 So. Hilton St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-6
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 265 So Hilton Pk
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Violet Green Peterson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	colored	married

6 (b) Name of husband or wife Morris Peterson
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) March 20, 1899

8. AGE: Years	Months	Days	If less than one day
48	2	13	— hr. — min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Domestic worker
11. Industry or business Private Home.

FATHER
12. Name Louis Green
13. Birthplace Maryland

MOTHER
14. Maiden Name Caroline Watts
15. Birthplace Maryland

16 (a) Informant Morris Peterson
(b) Address 265 So. Hilton

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-5-1947 (month) (day) (year)
(c) Cemetery or crematory Western Star.
Location Catonsville Md.

18 (a) Funeral director Mrs K. R Williams
(b) Address 322 N. Schroeder St.

19 (a) JUN 5 - 1947 (Date rec'd by registrar) Cemetery for Williams M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2, 1947 at 3 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 14 1947 to June 2 1947 and that I last saw her alive on June 1 1947.

Immediate cause of death: Metastatic carcinoma - gastro-intestinal tract — Duration ?
Due to Carcinoma uterus (radiation in March 1947) — ?
Due to
Other Conditions Valvular heart Disease
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James M. Lair
Address 400 N. Carrollton Ave Date signed 6/2/47 M. D.

X

G52322

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 46 B

Registered No. G52322

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Read & Cathedral St.
(c) Hospital or institution: Med ext. Alley
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 13 Fullerton Heights Ave
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph or Giuseppe Corteggiano

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 215-07-4768

4. Sex: male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lucy

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) May 29 1892

8. AGE: Years 55 | Months - | Days 5 | If less than one day ____ hr. ____ min.

9. Birthplace: Italy (Town, county, and state)

10. Usual Occupation: Tailor

11. Industry or business: Tailor Shop

FATHER
12. Name: Giuseppe Corteggiano
13. Birthplace: Italy

MOTHER
14. Maiden Name: Filomena Fortunata
15. Birthplace: Italy

16 (a) Informant: Lucy Corteggiano (Wife)
(b) Address: 13 Fullerton Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: June 6 1947 (month) (day) (year)
(c) Cemetery or crematory: Parkwood
Location: 3310 Taylor Ave Baltimore Md.

18 (a) Funeral director: Arnold Della Rosa
(b) Address: 52 N. Morley St.

19 (a) JUN 5 - 1947 (Date received by registrar) Huntington Williams, M.D. Address: Medical Arts Bldg

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 3 1947, at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 18 1946, to June 3 1947, and that I last saw him alive on June 3 1947.

Immediate cause of death: Carcinoma — Duration: ____

Due to: Gastric Hemorrhage — Duration: ____

Due to: ____ — Duration: ____

Other Conditions: ____ — Duration: ____

(Include pregnancy within 3 months of death)

Date of operation: Dec 30 1946

Major findings of operation: Extensive Carcinoma

of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Hartman F. Simm M. D.
Address: Medical Arts Bldg Date signed: 6/7/47

VS 150

X

G52323

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

F 3a

G52323
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Esplanade Apts. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ernestine Strauss (Ernestine E. Strauss)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sidney Strauss
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch. 7 1887

8. AGE: Years 60 | Months 2 | Days 28 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Herman Eisemann
13. Birthplace Germany

MOTHER
14. Maiden Name Rosa Brinsfelder
15. Birthplace Balto. Md.

16 (a) Informant Mr. Sidney Strauss
(b) Address Esplanade Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/ /47
(month) (day) (year)
(c) Cemetery Balto. Hebrew
Location Balto. Md.

18 (a) Funeral director Louis Sonnenstein & Son
(b) Address 120 N. Eutaw St. Balto.

19 (a) (Date received by registrar) 1947 (b) Registrar Hattie Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-4-47 1947 at 5:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-2 1947 to 6-4 1947 and that I last saw her alive on 6-4 1947.

	Duration
Immediate cause of death: Cerebral Hemorrhage	
Due to: Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nathan J. Nyman M. D.
Address Sinai Hospital Date signed 6-4-47

X

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52324

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G52324 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Sts
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Gambrills, Maryland
Rural. (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel D Hecht

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 006-09-0745

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ruth E. Hecht

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 28, 1866

8. AGE: Years 81 | Months 4 | Days 7 | If less than one day hr. min.

9. Birthplace Philadelphia, Pennsylvania (Town, county, and state)

10. Usual Occupation Interior Decorator

11. Industry or business S. T. Hecht Company

FATHER
12. Name Joseph Hecht
13. Birthplace Philadelphia, Pennsylvania

MOTHER
14. Maiden Name Sophia
15. Birthplace Philadelphia, Pennsylvania

16 (a) Informant Ruth Hecht
(b) Address Millersville, Maryland

17 (a) removal (Burial, cremation, or removal) (b) Date thereof 6/6/47 (month) (day) (year)
(c) Cemetery or crematory Bar Harbor
Location Bar Harbor, Maine

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) (Date received by registrar) [illegible] Registrar

JUN 5 - 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5th 1947, at 6 00 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/20/1947 to 6/5/1947, and that I last saw him alive on 6/5/1947

Immediate cause of death	Duration
Heart failure	
Due to C.C.V. disease & decompensation and uremia	15 days
Due to	
Other Conditions: Healed fracture right hip (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 2-20-47 at M
(c) Where did injury occur? Gambrills, Maryland (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? no
(e) Means of injury Slipped & fell on porch of home

23. Signature C. E. Gonzales
Address Maryland General Hospital Date signed 6/5/47

Howard J. Mullen, M.D.

G52325

BALTIMORE CITY HEALTH DEPARTMENT

DC# 679930 CERTIFICATE OF DEATH V 161c

Registered No. G52325

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr. 35 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - 16
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2643 Harlem Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paula Culver (Baby Girl)

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3, 1947

8. AGE: Years	Months	Days	If less than one day
			1 hr. 35 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Paul Lester Culver
13. Birthplace Hebron Maryland

MOTHER
14. Maiden Name Jeanette Anita Buckley
15. Birthplace Baltimore Md.

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (b) Date thereof 6/5/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Park Cemetery
Location Woodlawn Maryland

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pennsylvania Aves. Hamilton Baltimore, Md.

JUN 5 - 1947 (b) Registrar
(Local Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-3 1947 at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-3 1947 to 6-3 1947 and that I last saw h alive on 6-3 1947.

Immediate cause of death	Duration
Erythroblastosis fetalis	
Due to Rh incompatability	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. F. Barr M. D.
Address Bon Secours Hosp Date signed 6-4-47

VS 190

G52326

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 518

Registered No. G52326

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. Please write the causes of death clearly and legibly. Physicians: please write PLEASE WRITE PLAINLY, WITH UNFADING INK. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2219 Fleet Street
(c) Hospital or institution: 1-

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) 4
(d) Street No. 2219 Fleet Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY COYNE

3 (b) If veteran, name war
3 (c) Social Security Account No. 215-10-1763

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Katie
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) March 15, 1885

8. AGE: Years	Months	Days	If less than one day
62	2	19	hr. min.

9. Birthplace Lancaster, Penna. (Town, county, and state)
10. Usual Occupation Stationary Engineer
11. Industry or business Can Manufacturing

FATHER
12. Name Unknown Coyne
13. Birthplace Unknown

MOTHER
14. Maiden Name Lena Nath
15. Birthplace Lancaster, Penna.

16 (a) Informant Mrs. Katie Coyne
(b) Address 2219 Fleet Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/7/47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Avenue

18 (a) Funeral director M. J. Sadowski & Son,
(b) Address Eastern Avenue

19 (a) JUN 5 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 1947, at 1:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1947 to June 4 1947, and that I last saw him alive on June 3 1947.

	Duration
Immediate cause of death Myocardial Failure	2 days.
Due to Acute Coronary Occlusion	1 hr.
Due to Carcinoma of Prostate	4 yr.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George W. LeDoux M.D.
Address 601 S. Ellwood Ave. Date signed 6/5/47

G52327
16711

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
127a

Registered No. G52327

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2825 E. Biddle, St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Valeria Jednoralski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Stanislaus
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 3-18-77

8. AGE: Years	Months	Days	If less than one day
70	2	15	.....hr. .....min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation.....
11. Industry or business

FATHER
12. Name Marcus Reinert
13. Birthplace Germany?

MOTHER
14. Maiden Name Teofelia Kliesz
15. Birthplace Germany

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof June 6 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory [illegible]
Location Mt. Carmel Cem. Co.

18 (a) Funeral director M. F. Gadow Sons & Co.
(b) Address 1616 Eastern Ave

19 (a) JUN 5 - 1947 (b) Huntington Williams
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June - 2 - 1947 at 3:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-11-1947 to 6-2-1947 and that I last saw h[illegible] alive on 6-2-1947

Immediate cause of death	Duration
1. Cardiac failure	3 wks
2. Cerebro-vascular	3 wks
Due to acquired hemi-hypertension plegia	5 yrs
Due to	
Other Conditions Post-operative thrombophlebitis	3 wks

(Include pregnancy within 3 months of death)
Date of operation May 25 1947
Major findings of operation: Acute thrombophlebitis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature [illegible] M.D.
Address Johns Hopkins Hospital Date signed June 2nd 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G52328

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G52328 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address LAFAYETTE AND JOHN 18
(c) Hospital or institution:
HOSPITAL FOR THE WOMEN OF MARYLAND
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County —
(c) City or town BALTIMORE, MD
(If outside city or town limits, write RURAL and give town)
(d) Street No. 854½ W. LOMBARD ST
(If rural give location)
(e) Citizen of foreign country? YES (Yes or No)
If yes, name country LITHUANIA

3 (a) FULL NAME NELLIE — PRAVIDZAVICIUS

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife JOSEPH PRAVIDAVICIUS
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) UNKNOWN

8. AGE: Years	Months	Days	If less than one day
60	?	?	hr. min.

9. Birthplace LITHUANIA (Town, county, and state)
10. Usual Occupation H.W.
11. Industry or business HOME

FATHER
12. Name UNKNOWN
13. Birthplace UNKNOWN

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace UNKNOWN

16 (a) Informant MRS L. LINKA
(b) Address 647 PORTLAND ST. BALTO MD

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-6-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location Belair Road

18 (a) Funeral director Charles W. Sachsenmaier
(b) Address 703 McHenry St.

19 (a) JUN 5 1947 Registrar (b) Livingston Williams M.D.

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 JUNE 19 47, at 9 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 30 APR 19 47, to 2 JUNE 19 47, and that I last saw HER alive on 2 JUNE 19 47.

Immediate cause of death	Duration
CARDIO RESPIRATORY FAILURE	
Due to UREMIA	2 DAYS
Due to HYPERTENSIVE CARDIO-RENAL DISEASE	1 YRS
Other Conditions DIABETES MELLITUS ANEMIA	6 YRS

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations
of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fred B Agre Jr M. D.
Address Woman's Hospital Date signed June 7

1310

G52329

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓106R

Registered No. G52329

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 615-14 Division St.
(c) Hospital or institution: Provident Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 925 W. Fayette (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Anderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Married

6 (b) Name of husband or wife Lillian Anderson
6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) Aug. 4, 1906

8. AGE: Years	Months	Days	If less than one day
40	9	29	____ hr. ____ min.

9. Birthplace Sumpter, South Carolina (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name William Anderson
13. Birthplace , South Carolina

MOTHER
14. Maiden Name Emily Peterson
15. Birthplace Sumter, South Carolina

16 (a) Informant Lillian Anderson
(b) Address 925 W. Fayette

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 6-6-1947 (month) (day) (year)
(c) Cemetery or crematory Sumter
Location South Carolina.

18 (a) Funeral director Mrs R. R. Wallace
(b) Address 322 N. Schroeder St.

19 JUN 5 - 1947 (Date rec'd by registrar) Transferred to Williamsburg, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1947, at 5:17 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 29 1947, to June 3 1947, and that I last saw him alive on June 3 1947.

Immediate cause of death	Duration
Lung Abscesses	
Due to	over
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Percival C. Smith M. D.
Address 615-14 Division St. Date signed 6-5-47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52330

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. G52330

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution:
St Josephs Hospital 1-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 52

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2310 Cambridge St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Elizabeth Kopczynski KOPCZENSKI

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-07-6484

4. Sex F | 5. Color or race W | 6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~.

6 (b) Name of husband Walter

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) April 9-1896

8. AGE: Years 51 | Months 12 | Days 26 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Anthony STRUZYKOWSKI
13. Birthplace Poland

MOTHER 14. Maiden Name Apolonia DZADOSEK
15. Birthplace Poland

16 (a) Informant Wladyslaw KOPCZENSKI
(b) Address 2310 Cambridge st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-7-47 (month) (day) (year)

(c) Cemetery or crematory St Stanislaus
Location Baltimore Md.

18 (a) Funeral director George A Weber
(b) Address 7 [illegible] S Linn st

19 (a) JUN 5 - 1947 (Date rec'd by registrar) (b) Hamilton Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/5 1947 at 7:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/31 1947 to 6/5 1947 and that I last saw her alive on 6/4 1947

Immediate cause of death ..... Duration
Generalized Carcinomatosis
Due to Carcinoma of the Cervix
Due to Pyelonephritis
Other Conditions Hypertension C.V. Disease
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard H. Feeney M.D.
Address St Joseph Hosp Date signed 6/5/47

VS 150

G52331

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

838

Registered No. G52331

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Garrison Blvd.
(c) Hospital or institution: 15-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3312 Carlisle Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANNIE L. FULLBAUER

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: George Fullbauer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 28, 1861

8. AGE: Years 85 | Months 7 | Days 10 8 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Richard Auld
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Ford
15. Birthplace Md

16 (a) Informant Mr. Irving Fullbauer
(b) Address 1406 Rosedale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/6/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM.J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUN 5 1947 (Date received by registrar) (b) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5, 1947, at 6:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 7 1947, to June 5 1947, and that I last saw h[illegible] alive on June 3, 1947.

	Duration
Immediate cause of death: Cerebral Thrombosis	4 days
Due to: Cerebral Sclerosis	Years
Due to:	
Other Conditions: Senility	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]
Address 651 N. Rentalou Str. Date signed M. D. 6/4/47

G52332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Volume 57B

Registered No. G52332

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1807 Whitmore Ave.
(c) Hospital or institution: 15 3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 Whitmore Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LEE HUNT ANDERSON

3 (b) If veteran, name war: Spanish Amer.
3 (c) Social Security Account No.:

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: Mary K. Anderson
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) 6/3/~~88~~ 78

8. AGE: Years ~~89~~ 69 | Months - | Days 1 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Janitor
11. Industry or business

FATHER — 12. Name Richard F. Anderson
13. Birthplace Va.

MOTHER — 14. Maiden Name unk.
15. Birthplace

16 (a) Informant Elmer Anderson
(b) Address 1808 Braddick Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/7/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUN 5 - 1947 (Date rec'd by registrar) (b) Huntington-Williamsport, Inc.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/4/47 19 , at 6 30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/1 19 47 to 6/4 19 47.
and that I last saw him alive on 6/4 19 47.

Immediate cause of death: Brain tumor — Duration: 8 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature, Sheldon Davis M. D.
Address 244 N. Milton Ave. Date signed 6/4/47

XJ

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52333

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 309

G52333 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2618 Pierpont street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 18 years.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2618 Pierpont street
(If rural give location)
(e) Citizen of foreign country? Citizen (Yes or No)
If yes, name country

3 (a) FULL NAME Lucille Agnes Wallace

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	col.	married

6 (b) Name of husband or wife Robert Wallace
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Feb 15 1907

8. AGE: Years	Months	Days	If less than one day
40	3	18	hr. min.

9. Birthplace Knoxville Tennessee
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Tillay
13. Birthplace Knoxville, Tennessee?

MOTHER
14. Maiden Name [illegible] Hinrichs
15. Birthplace Knoxville Tennessee

16 (a) Informant Robert Wallace
(b) Address 2618 Pierpont st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 8 1947 (month) (day) (year)
(c) Cemetery or crematory Bloch Rak Conn
Location Knoxville Tenn.
18 (a) Funeral director Chas O. Wilson
(b) Address 1000 Bentley Ave
19 (a) 1947 (b) Registered by registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2nd 1947, at 10 10 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1947, to June 2nd 1947, and that I last saw h[illegible] alive on June 2 1947.

Immediate cause of death	Duration
congestive heart failure	3 months
Due to cardio-vascular-renal disease	
Due to [illegible]	
Other Conditions Fibroids of uterus	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter L. Sourwine M. D.
Address 2708 Kelly Ave Date signed 6/3/47

G52334 BALTIMORE CITY HEALTH DEPARTMENT G52334

CERTIFICATE OF DEATH

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fulton & Pendleton Sts.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town White Hall
(If outside city or town limits, write RURAL and give town)
(d) Street No. -
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Adolphe Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Catherine Johnson
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) March 5 1881

8. AGE: Years	Months	Days	If less than one day
66	2	27	..... hr. ..... min.

9. Birthplace Mt Horeb Harford Co Md
(Town, county, and state)
10. Usual Occupation Auto mechanic
11. Industry or business Retired

FATHER
12. Name George Johnson
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine Adams
15. Birthplace Md.

16 (a) Informant Mrs Henry Johnson.
(b) Address White Hall Md.

17 (a) Burial (b) Date thereof June 7-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bethel
Location Madonna, Harford Co Md

18 (a) Funeral director Marion Grant
(b) Address Jarrettsville Md.

JUN 5 1947
(Date rec'd by registrar) (Signature of registrar) Thomas Jon Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/5 1947 at 7 55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/4 1947 to 6/5 1947 and that I last saw him alive on 6/5 1947

Immediate cause of death Hemopericardium with cardiac tamponade — Duration

Due to Dissecting Aortic Aneurysm & ruptures — Duration

Due to ..... — Duration

Other Conditions ..... — Duration

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: .....

of autopsy: above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature John E Miller M.D.
Address Maryland Gen'l Hosp. Date signed 6/5/47

VS 150

G52335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered G52335

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland 5th Division

(b) Street address 1100 Loon

(c) Hospital or institution: Provident

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 dy.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1609 W. Saratoga (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Junior Hayes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	N	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years	Months	Days	If less than one day
49?			hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory 5 1947

Location University Medical School JUN 5 1947

18 (a) Funeral director Commissioner of Health

(b) Address

19 JUN 6 - 1947 (b) Registered by [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/2 1947 at 6 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/15 1947 to 5/2 1947 and that I last saw h[illegible] alive on 5/2 1947.

Immediate cause of death Antemortem clot

Heart disease 1 month

Due to

Due to

Other Conditions Malnutrition

Anemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
1
1

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature James D. Carr, M. D.

Address 515 Mosher St Date signed 5-3-47

VS 150

G52336

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G52336 Registered No.

GM 16373

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern AVE.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 9 11
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 215 S. Colvin ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Richardson Jennie

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1861

8. AGE: Years	Months	Days	If less than one day
86	?	?	hr. min.

9. Birthplace MD. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name ?
13. Birthplace ?

MOTHER 14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records, alto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School JUN 5 1947

18 (a) Funeral director Commissioner of Health
(b) Address

JUN 6 - 1947 (Date rec'd by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 - 1947, at 2.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 13 1936 to May 24 - 1947, and that I last saw h alive on May 24 - 1947

Immediate cause of death: Cerebrovascular accident — Duration: 2 days.
Due to: Arteriosclerotic heart disease with generalized arteriosclerosis.
Due to: (a) Carcinoma of ureter primary site unknown
Other Conditions: (b) Pathological fracture right femur
(Include pregnancy within 3 months of death)
Date of operation 4/15/47
Major findings of operation: Fracture of right femur.
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident 26-17
(b) Date of occurrence April 7 1947 at Unknown P.M.
(c) Where did injury occur? Bethlehem, Baltimore, Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? B.C.H. Infirmary (Specify type of place) While at work? No
(e) Means of injury Unknown
23. Signature R. D. Gibbs M.D.
Address Baltimore City Hospitals Date signed 5/24/47

VS 150

To be approved by Medical Examiner
for C. J. Schandelle M.D. by
Howard J. Moreau, M.D.

G52337 Birth Certificate No. 86350

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G52337

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2921 Walbrook Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Schroeder

3 (b) If veteran, name war

3 (c) Social Security Account No.

Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-24-47

8. AGE: Years	Months	Days	If less than one day
		2	1 hr. — min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Walter Schroeder
13. Birthplace Georgia

MOTHER — 14. Maiden Name Alma Hartzog
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo JUN 2 1947

18 (a) Funeral director Commissioner of Health
(b) Address

JUN 6 1947 (Date Rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-27-1947 at 2:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-25 1947 to 5-27 1947 and that I last saw h[illegible] alive on 5-27-1947.

Immediate cause of death	Duration
Asphyxia	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lee Neil Bass M. D.
Address Johns Hopkins Hosp. Date signed 5-27-47

G52338 BCH# B81109 516013. BALTIMORE CITY HEALTH DEPARTMENT G52338

CERTIFICATE OF DEATH 159

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 702 S. Light St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Nelson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-26-47

8. AGE: Years	Months	Days	If less than one day
		34	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Russell Nelson
13. Birthplace Ohio

MOTHER
14. Maiden Name Mildred Stallmaker
15. Birthplace Md

16 (a) Informant Rhonda
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Local Johns Hopkins Medical School JUN 2 1947
18 (a) Funeral director Commissioner of Health
(b) Address
JUN 6 1947 (Date rec'd by local registrar)

MEDICAL CERTIFICATION A

20. DATE OF DEATH May 30 1947 at 1245 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 26 1947 to May 30 1947 and that I last saw him alive on May 30 1947.

Immediate cause of death	Duration
Septicemia	24 hrs.
Due to	
Due to	
Other Conditions Prematurity (Premature)	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature D. D'Esopo M. D.
Address Johns Hopkins Hosp. Date signed May 31-47

VS 150

G52339

BALTIMORE CITY HEALTH DEPARTMENT

BC# D80299 CERTIFICATE OF DEATH 159

G52339
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mendenhall & Sanden
(c) Hospital or institution: Mrs. Jno. Hopkins
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3225 Milford Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Girl Smith

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Newborn

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/29/47

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name William J. Smith Jr.
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Alice J. Kelly
15. Birthplace Balto. Md.

16 (a) Informant Mother
(b) Address 3225 Milford

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School JUN 2 1947

18 (a) Funeral director Commissioner of Health
(b) Address

JUN 6 - 1947 Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/29/47 19 at 10P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/29/47 19 to 5/29/47 19 and that I last saw him alive on 5/29/47 19

Immediate cause of death	Duration
Prematurity	
Due to Pregnancy 6 Months	
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas C. Waldo, M.D.
Address Md. Jno. Hopkins Date signed 5/29/47

652340

BALTIMORE CITY HEALTH DEPARTMENT

GM. 15887

CERTIFICATE OF DEATH 47

Registered No. 652340

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 - 8 -27
(e) Length of stay in Baltimore (yrs., mos., or days) 9Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 620 N. Bond ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Kunkelowski Mary

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Edgar (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1862 ?? - ?

8. AGE: Years	Months	Days	If less than one day
85	?	?	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name M. Bielanski
13. Birthplace Poland

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/6/47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location German Hill Rd

18 (a) Funeral director John J. Fahey & Son.
(b) Address 1017 Light St.

19 (a) JUN 6 1947 (Date received by Local Registrar) (b) Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30- 1947, at 1:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9 -3 - 1931 to May - 30 1947, and that I last saw h er alive on May -30 1947.

Immediate cause of death	Duration
Respiratory Failure	
Due to Chronic bronchitis and emphysema.	
Due to	
Other Conditions Metastatic malignancy lungs - source unknown. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Emma Readau M. D.
Address Balto City Hosp Date signed 6/7/47

106 B

52341 J1 - 110629

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G52341 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 612 E. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Hoff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age (8) years

7. Birth date of deceased (mo., day, yr.) Sept. 26, (1878)

8. AGE: Years	Months	Days	If less than one day
68	8	6	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Hoff
13. Birthplace Germany

MOTHER 14. Maiden Name Frances Miller
15. Birthplace Germany

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/6/47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Berman Hill Rd

18 (a) Funeral director John J. Fahey & Sons
(b) Address 1308 Light St.

JUN 6 - 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2, 1947 19 ; at 9:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 13 1947 to June 2 1947, and that I last saw h. in alive on June 2 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Bronchopneumonia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Doyle Walker M. D.
Address B.C.H. Date signed 6-4-47

G52342

BALTIMORE CITY HEALTH DEPARTMENT

BCH B79946 CERTIFICATE OF DEATH 30F

G52342 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 da.

2. USUAL RESIDENCE OF DECEASED Anne Arundel
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Franklin Square Hospital.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Mc Lean.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31, 1947

8. AGE: Years | Months | Days | If less than one day 13 hr. 2 min.

9. Birthplace Baltimore, Baltimore Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Charles Mc Lean
13. Birthplace Newark, N. J.

MOTHER 14. Maiden Name Ray Lavine Smith
15. Birthplace Spring Lake, N. J.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School JUN 4 1947

18 (a) Funeral director Commissioner of Health
(b) Address

JUN 6 - 1947 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 1947, at 8:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/31 1947 to 6/1 1947, and that I last saw him alive on 6/1 1947

Immediate cause of death: Intracranial hemorrhage — Duration

Due to Congenital syphilis

Due to

Other Conditions None

(Include pregnancy within 3 months of death)
Date of operation None.
Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hayden B. Mcmanaway M.D.
Address Franklin Sq. Hosp. Date signed 6-2-47

G52343

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G52343
Registered No.

CERTIFICATE OF DEATH 159

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Elkridge
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Saylor

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5 31 47

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name Oscar Saylor
13. Birthplace Ky
MOTHER 14. Maiden Name Margaret Delowder
15. Birthplace Md
16 (a) Informant Record
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Loc Johns Hopkins Medical School JUN 2 1947
18 (a) Funeral director Commissioner of Health
(b) Address
JUN 6 - 1947 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 1947, at 8 35 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 30 1947 to June 1 1947 and that I last saw h alive on June 1 1947

Immediate cause of death	Duration
asphyxia	
Due to	
Due to	
Other Conditions Prematurity (1 2 0 gm)	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lee N. Bass M. D.
Address Johns Hopkins Hosp Date signed 6-1-47

VS 150

C52344

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. C52344

GM. 110901

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 11Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryla nd (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 38 S. Fulton AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Knapp Elsie (Elsie G.Knapp)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Joseph (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March -13,189[illegible]

8. AGE: Years	Months	Days	If less than one day
57	2	22	hr. min.

9. Birthplace MD.a (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER — 12. Name Peter Mehring(D)

13. Birthplace Germany

MOTHER — 14. Maiden Name Margaret Mann (D)

15. Birthplace Germany

16 (a) Informant Records Balto. City Hospitals

(b) Address 4940 Eastern AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 7th1947 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cem

Location Balto. Cem.

18 (a) Funeral director Philip Mowing Sons

(b) Address 2024 Orleans St.

19 JUN 6 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5 - 1947, at 3.22A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 24 - 1947 to June 5 - 1947, and that I last saw her alive on June 5 - 1947

Immediate cause of death: Hypertensive Cardio-vascular disease — Duration 4yrs

Due to:

Due to:

Other Conditions Pulmonary Tuberculosis

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide:

(b) Date of occurrence: at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury:

23. Signature A H Hait M. D.

Address Balto City Hosp Date signed 6/6/47

93D

G52345

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

JUN 6 - 1947

Registered No. G52345

833a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2400 Reisterstown Road.
(c) Hospital or institution:

15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2400 Reisterstown Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob J Kahn

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Late Fannie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 22 1884

8. AGE: Years 62 | Months 11 | Days 13 | If less than one day ... hr. ... min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business: None

FATHER
12. Name: Abraham Kahn
13. Birthplace: Russia

MOTHER
14. Maiden Name: Hannah Ayman
15. Birthplace: Russia

16 (a) Informant: Maurice A Cohen
(b) Address: 9 N Gay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: June 6, 1947 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Rosedale Cem
Location: Hamilton Ave

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 11241126 W North Ave

19 (a) JUN 6 - 1947 (Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 5, 1947, at 1.40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945, to June 5, 1947, and that I last saw him alive on June 5, 1947.

Immediate cause of death: Cerebral Hemorrhage — Duration: 5 days.

Due to: Arteriosclerosis

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Nathan H Spritz M.D.
Address: 1810 Eutaw Pl. Date signed: 6/5/47

VS 150

G52346 Kocent

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No. G52346

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3201 Dudley Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3201 Dudley Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Leon G. Kocent

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11 1904

8. AGE: Years	Months	Days	If less than one day
43	1	22	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation meat cutter
11. Industry or business

FATHER 12. Name Andrew Kocent
13. Birthplace Poland

MOTHER 14. Maiden Name Mary Zoran
15. Birthplace Poland

16 (a) Informant Mary Kocent
(b) Address 3201 Dudley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/7/47 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Dundalk Ave

18 (a) Funeral director John J. Duda
(b) Address 2049 Hudson St

19 JUN 6 - 1947 (Date received by registrar) Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/3/47 19 , at 9 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1/46 19 to 6/3/47 19 , and that I last saw h[im] alive on 6/3/47 19 .

Immediate cause of death Cerebral Coma — Duration 1 hr.
Due to Myocardial Degeneration — 1 yrs.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. J. Feerman M. D.
Address 1710 E. 33rd St Date signed 6/5/47

G52347 BALTIMORE CITY HEALTH DEPARTMENT

Mu/Rooney CERTIFICATE OF DEATH 137a Registered No. G52347

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 months
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1418 Sulgrave J Poor
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Michael Mulrooney
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of ~~husband~~ or wife late Rose Agnes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 26, 1866

8. AGE: Years 80 | Months 8 | Days 9 | If less than one day ... hr. ... min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER 12. Name Anthony Mulrooney
13. Birthplace Ireland

MOTHER 14. Maiden Name Bridget Clark
15. Birthplace Ireland

16 (a) Informant Mrs Agnes Sullivan
(b) Address 408 Lyndhurst St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 7, 1947 (Month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location 4300 Old Frederick Rd

18 (a) Funeral director Harry A Wright
(b) Address 401 Edmondson Ave

JUN 6 - 1947 (Date rec'd by Registrar) (b) Huntington Hollins M.D.

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/5 1947 at 10:17 A.M

21. I certify that death occurred on the date above stated, that I attended deceased from 4/4/47 19... to 6/5 1947, and that I last saw him alive on 6/5 19 47

Immediate cause of death: Cardio Respiratory Failure — Duration
Due to: Uremia
Due to: Hypertrophied prostate (adenocystic)
Other Conditions
(Include pregnancy within three months of death)
Date of operation 4/6/47
Major findings of operation: Prostatic Hypertrophy
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry T. Walsh Jr. M.D.
Address St. Joseph's Hosp. Date signed 6/5/47

G52348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. G52348

GM. 108190

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 29 Y
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 106 S. Monroe ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gibbs, Hattie Pauline

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Seperated

6 (b) Name of husband or wife Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25 - 1913

8. AGE: Years	Months	Days	If less than one day
33	6	9	hr. min.

9. Birthplace VA.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Price Piner
13. Birthplace VA.

MOTHER
14. Maiden Name Mable Harper
15. Birthplace VA.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/7/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location 3801 Frederick Rd

18 (a) Funeral director Henry H. Wittle
(b) Address 4101 Edmondson Ave

19 JUN 6 - 1947 (Date rec'd by registrar) Huntington Wilkerson

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 - 1947, at 10.50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 5 - 47 to June 4- 47, and that I last saw her alive on June 4 - 1947

Immediate cause of death	Duration
Carcinoma of rectosigmoid, with metastases	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 2-18-47
Major findings of operation: Abscess
of autopsy Abscess

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice M. Lasy, M.D.
M. D.
Address Baltimore City Hosps. Date signed 6-4-47

X

G52349 BALTIMORE CITY HEALTH DEPARTMENT ✓ Registered No. G52349

Botelor CERTIFICATE OF DEATH 1209

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore Gen. Hosp. ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1839 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Irwin Botteler (Botelor) D.J.H ✓

3 (b) If veteran, name war:

3 (c) Social Security Account No. 705-07-8241

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Laura L (Travis)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 17, 1898

8. AGE: Years	Months	Days	If less than one day
48	7	18	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business B & O. Railroad

FATHER
12. Name Wm G Botelor
13. Birthplace Maryland

MOTHER
14. Maiden Name Martha R Wilson
15. Birthplace Maryland

16 (a) Informant Mrs Laura L Botelor
(b) Address 1839 Edmondson Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof June 7 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3901 Frederick Ave

18 (a) Funeral director Harry A W Tyler
(b) Address 4196 Edmondson Ave

19 (a) JUN 6 - 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5 1947, at 1 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute gastro-enteritis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earle Ryder M.D. (Medical Examiner.)
Date signed 6-5-47

VS 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C52350

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 457

Registered No. C52350

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 428 E. 22½ St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 428 E. 22½ St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Burrell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Edward

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 13-1884

8. AGE: Years 62 | Months 7. | Days 21 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Giden Brockett
13. Birthplace — — — — N/A

MOTHER
14. Maiden Name Rose Brockett
15. Birthplace — — — — N/A

16 (a) Informant Lillian Garrett
(b) Address 453 E. 23rd St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 6, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County

18 (a) Funeral director Raynor Sanders
(b) Address 1412 E. Preston St.

19 (a) JUN 6 - 1947 (Registrar's signature) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1947, at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1946 to June 3 1947 and that I last saw h-x alive on June 3 1947.

Immediate cause of death Carcinoma Lower Left Jaw, Mandible.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

Duration
1 yr.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. A. Johnson M. D.
Address 2329 Guilford Ave Date signed June 5 1947

VS 150

X

G52351

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ Registered No. G52351 123 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State [illegible] (b) County
(c) City or town Woodbridge N. J.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 274 (Woodbridge) AVe
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry H. Kleinberger

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Sybil
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28, 1903

8. AGE: Years	Months	Days	If less than one day
43	10	9	hr. min.

9. Birthplace Lima Ohio (Town, county, and state)
10. Usual Occupation
11. Industry or business Doctor

FATHER 12. Name Samuel Kleinberger
13. Birthplace Hungary

MOTHER 14. Maiden Name Rachel Hastung
15. Birthplace Indiana

16 (a) Informant Sybil Kleinberger
(b) Address 274 (Woodbridge) Ave Woodbridge N. J.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 8, 1947 (month) (day) (year)
(c) Cemetery or crematory Beth Israel Cemetery
Location Woodbridge N. J.

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) Filed JUN 6 1947 (b) [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/5 1947, at 6:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/27 1947 to 6/5 1947 and that I last saw him alive on 6/5 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Uremia	
Due to Polycystic Kidneys	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 6/3/47
Major findings of operation: polycystic kidneys
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold M. Jordan M. D.
Address Sinai Hosp Date signed 6/5/47

X

G52352

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G52352

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3721 Keswick Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3721 Keswick Rd. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Kimball Rogers

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-09-0459

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ellen S. Rogers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1886

8. AGE: Years	Months	Days	(If less than one day hr. min.)
60	6	17	

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Printing
11. Industry or business

FATHER
12. Name Franklin D. Rogers
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie Williams
15. Birthplace Maryland

16 (a) Informant Mrs. Ellen S. Rogers
(b) Address 3721 Keswick Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 7-1947 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 JUN 6 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5 1947, at 5:30 P M

21. I certify that I took charge of the remains described above, held an Inqu. & Exp. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Masters M.D. Medical Examiner.
Date signed 6-5-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52353

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G52353

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2421 Hudson Pl.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2421 Hudson Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Addie Hill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Old age pension
(b) Address

17 (a) Burial (b) Date thereof June 6 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 JUN 6 - 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27, 1947, at 6 P. M.

21. I certify that I took charge of the remains described above, held an Insp. - Inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Generalized arteriosclerotic cardiovascular disease.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D.
Medical Examiner
Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C52354

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

89a

Registered No. C52354

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 504 Ogaton St.
(c) Hospital or institution:
17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 504 Ogaton St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Washington Booker

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-5022

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1, 1902

8. AGE: Years 45 | Months | Days 2 | If less than one day hr. min.

9. Birthplace Richmond, Va (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Louis T. Booker
13. Birthplace Richmond, Va

MOTHER 14. Maiden Name Virginia Fountain
15. Birthplace Richmond, Va

16 (a) Informant Louis T. Booker
(b) Address 1534 Argyle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 5, 1947 (mo.) (day) (yr.)
(c) Cemetery or crematory Woodlawn Mem. Park
Location Baltimore County, Md.

18 (a) Funeral director Geo. H. Holland
(b) Address 1631 Druid Hill Ave

19 JUN 6 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 1947 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1947 to June 2 1947 and that I last saw him alive on 19

Immediate cause of death

(a) Cerebral Hemorrhage — Duration 10 hrs
Due to Uremia & Nephritis

(b) Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 1534 Argyle Ave Date signed 6/6/47

V S 150

G52355

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 307

G52355 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct... is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 645 W. Lafayette ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 645 W. Lafayette Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Hunter

3 (b) If veteran, name war W.W. I

3 (c) Social Security Account No. 218-05-0182

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/23/1888

8. AGE: Years	Months	Days	If less than one day
58	8 mo	10	hr. min.

9. Birthplace Georgia (Town, county and state)

10. Usual Occupation Waiter

11. Industry or business

FATHER
12. Name Fred Hunter
13. Birthplace Ga

MOTHER
14. Maiden Name Minnie Miller
15. Birthplace Ga

16 (a) Informant Minnie Mims

(b) Address 1370 N. Fremont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/9/47 (month) (day) (year)

(c) Cemetery or crematory Balto Nat M

(a) Funeral director Wes. G. Kelson

(b) Address 4303 Pressman St Baltimore Md

6 JUN 1947

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1947, at PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Syphilitic aortitis
Meningitis
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 6/3/47

VS 181

G52356

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G52356 Registered No. 83B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green St.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3249 E. Balto. St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Jacob Wise

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	divorced

6 (b) Name of husband or wife Catherine Wise
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 26th 1866

8. AGE: Years	Months	Days	If less than one day
81 82	2	10	hr. min.

9. Birthplace Pa. (Town, county and state)
10. Usual Occupation retired Cooper.
11. Industry or business

FATHER
12. Name Wm. Wise.
13. Birthplace Germany.

MOTHER
14. Maiden Name Unknown.
15. Birthplace "

16 (a) Informant William Wise.
(b) Address 363 Mc. Cauley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 9, 1947 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director Dill Bros.
(b) Address 3109 Fredk. Ave.

19 (a) (Date received by registrar) (b) Registrar

JUN 9 1947 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5 1947, at 8 29 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-2 1947 to 6-5 1947 and that I last saw him alive on 6-5 1947

Immediate cause of death	Duration
Cerebral thrombosis	
Due to Marked arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Gerald A. Martin M. D.
Address Univ. Hosp. Date signed 6-5-47

X

G52357 G52357

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3329 Caton Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3329 Caton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herman A. Kassakatis.

3 (b) If veteran, name war: none.

3 (c) Social Security Account No. 364-09-9090.

4. Sex: male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Hettie M. Kassakatis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1 - 1903

8. AGE: Years 44 | Months 5 | Days 2 | If less than one day: hr. min.

9. Birthplace Baltimore - Md.
(Town, county, and state)

10. Usual Occupation Farmer.

11. Industry or business Weather Stripping Co.

FATHER
12. Name Herman G. Kassakatis.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mollie P. Riley.
15. Birthplace Baltimore - Md.

16 (a) Informant Mrs. Hettie M. Kassakatis.
(b) Address 3329 Caton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June, 7-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location

18 (a) Funeral director Charles J. Schwab
(b) Address 3512 Frederick Ave.

19 (a) (Date received by registrar) 6-1947 (b) Harrington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June, 3rd. 1947, at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-2 1947 to 6-3 1947 and that I last saw h[illegible] alive on 6-3 1947.

Immediate cause of death: Acute Cardiac Failure — Duration: 1 da

Due to: Caremona Rt Kidney — Duration:

Due to: with Metastasis — Duration: 3 yr

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dwight G. Lanteaux M.D.

Address 716 Washington Blvd. Date signed 6-4-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G52358 — G52358 No. 74a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2305 N. Monroe (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Henry F. Lindeman (HENRY F. LINDEMAN)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: (Married)

6 (b) Name of husband or wife: ROSA C. LINDEMAN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 11 - 5 - 1887

8. AGE: Years 59 | Months 6 | Days 28 | If less than one day: ******** hr. ******** min.

9. Birthplace: BALTIMORE MARYLAND (Town, county, and state)

10. Usual Occupation: ENGINEER RAILROAD

11. Industry or business: BALTIMORE & OHIO R.R.

FATHER — 12. Name: JOHN LINDEMAN
13. Birthplace: MARYLAND

MOTHER — 14. Maiden Name: ANNA WOLF
15. Birthplace: MARYLAND

16 (a) Informant: MRS ROSA C. LINDEMAN
(b) Address: 2305 N. MONROE STREET

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JUNE 6/47 (month) (day) (year)
(c) Cemetery or crematory: LOUDON PARK CEMETERY
Location: BALTIMORE, MARYLAND

18 (a) Funeral director: F. B. Wippert & Son
(b) Address: F.B.WIPPERT & SON.. 1300 EUTAW PLACE..17

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

JUN 6 - 1947

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/3/47 19 8:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/23 1947 to 6/3 1947 and that I last saw h. i. alive on 6/3 1947.

Immediate cause of death: Cerebral + Intestinal hemorrhage — Duration:
Due to: Acute myeloid Leukemia
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Richard H. Young M. D.
Address: St. Joseph's Hosp. Date signed 6/3/47

G52359

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G52359 Registered No. 1248

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1899 Alisanna st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace Woodfield mont. Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Millard F Thompson
13. Birthplace Woodfield Md.

MOTHER
14. Maiden Name Julia A Duvall
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof 6, 8, 47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or ~~crematory~~ Baptist Church
Location Cedar Grove Md

18 (a) Funeral director Payne Bailey
(b) Address Laytonsville Md

19 (a) 6 1947 (b) Registrar Lucretia Williams
(Date received by registrar)

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/4 1947, at 3 50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral edema

Due to

Other Conditions Fatty degeneration of liver
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer, M.D. M.D.
Medical Examiner.

Date signed 6-6-47

G52360

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1579

G52360

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Somerset
(a) State Md (b) County Princess Anne
(c) City or town Princess Anne.
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Powell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-1-47.

8. AGE: Years	Months	Days	If less than one day
		4 3	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Edward Powell
13. Birthplace Md

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant Parents
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-9-47 (month) (day) (year)
(c) Cemetery or crematory Methodist Cemetery
Location Princess Anne, Md.

18 (a) Funeral director Isabelle Funeral Home
(b) Address Princess Anne, Md.

JUN 6 - 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June - 4 1947, at 11 40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June-4 1947, to June-4 1947, and that I last saw alive on June-4 1947.

Immediate cause of death: RESPIRATORY FAILURE — Duration

Due to ATALECTASIS RIGHT UPPER LOBE, BILATERAL PNEUMONIA — 3 DAYS

Due to TRACHEO-ESOPHAGEAL FISTULA — 4 DAYS

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 6-4-47

Major findings of operation: TRACHEO-ESOPHAGEAL FISTULA

of autopsy: Tracheo-esophageal fistula

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. F. Cosby, Jr. M. D.

Address Johns Hopkins Hosp. Date signed 6-6-47

For C. J. Gulinsky by X
Howard J. Greene, M.D.

G52361 UNVERZAGT

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131a

G52361
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lundeen Ave & Madison St.
(c) Hospital or institution: Maryland General Hospital yes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 64 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 935 N. Collington Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Emile A. Unverzagt.

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-09-8850

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Katherine Deetz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4, 1882

8. AGE: Years	Months	Days	If less than one day
64	11	29	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and State)
10. Usual Occupation Pipe cutter
11. Industry or business

FATHER
12. Name August Unverzagt
13. Birthplace Hagerstown Md

MOTHER
14. Maiden Name Elda Collison
15. Birthplace Carroll Co Md

16 (a) Informant Henry Unverzagt (Son)
(b) Address 935 N Collington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/7/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd Baltimore

18 (a) Funeral director J. Melville Jenkins
(b) Address 2716 Kirk Ave

6/6 1947 (Date) registrar Williams M.D. (Deputy registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 June 1947 at 4:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 16 May 1947 to 3 June 1947 and that I last saw h. alive on 3 June 1947

Immediate cause of death: Uremia — Duration 17 days
Due to: Chronic nephritis — 5 years
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. Allan Ross M. D.
Address MD Gen Hosp Date signed June 47

G52362

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1928

Registered No. G52362

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2916 Guilford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2916 Guilford (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Margaret Coleman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 3-1890

8. AGE: Years	Months	Days	If less than one day
56	6	2	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Bookkeeper

11. Industry or business

FATHER 12. Name Thos Coleman

13. Birthplace Ireland

MOTHER 14. Maiden Name Mary Rafferty

15. Birthplace Ireland

16 (a) Informant Miss Ann Coleman

(b) Address 2916 Guilford

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/7/47 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Old Frederick

18 (a) Funeral director J. J. Doherty Sons

(b) Address 1218 Light St

19 JUN 6 - 1947 (Date filed by Registrar) Wilhelmina Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5 1947, at 2:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1929 to June 5 1947, and that I last saw her alive on June 5 1947.

Immediate cause of death	Duration
Congestive Heart Failure (Edema of Lungs)	9d
Due to Rheumatic Valvular Disease (Mitral Stenosis)	years
Due to Bacterial Endocarditis (Streptococcus)	1945.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Carroll Lockard M. D.

Address 2925 N Charles St Date 5 June 47

VS 150

G52363

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G52363

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 513 W. Vine St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 9/12
(e) Length of stay in Baltimore (yrs., mos., or days) 24 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 513 W. Vine St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Cooper
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Susie Penny
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1895
8. AGE: Years 52 | Months | Days | If less than one day hr. min.
9. Birthplace Chester, S. C.
(Town, county and state)
10. Usual Occupation Laborer - farming plant
11. Industry or business

FATHER 12. Name
13. Birthplace
MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant Wife
(b) Address 513 W. Vine St.
17 (a) Interment (Burial, cremation, or removal) (b) Date thereof 6/6/47 (month) (day) (year)
(c) Cemetery or crematory Pleasant View Memorial Park Co.
Location Chester, S. C.
18 (a) Funeral director Charles H. Alexander
(b) Address 1202 McCulloh St.
19 JUN 6 - 1947 Worthington Williams, M.D.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6, 1947, at 11:35 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from May 24 1947 to June 6 1947 and that I last saw him alive on June 1, 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Prostatic Malignant Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. T. Anderson M.D.
Address 513 W. Vine St. Date signed 6-6-47

VS 150

G52364

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G52364

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2930 GUILFORD AVE.
(c) Hospital or institution: NONE
(d) Length of stay in hospital or inst. (yrs., mos., or days) NONE
(e) Length of stay in Baltimore (yrs., mos., or days) 40 YEARS

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND. (b) County
(c) City or town BALTIMORE CITY.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2930 GUILFORD AVE
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES A. WEBB.

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Mary V. Webb (nee Massey) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1864

8. AGE: Years	Months	Days	If less than one day
82	10	12	hr. min.

9. Birthplace Somerset Co., Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John H. Webb
13. Birthplace Somerset Co., Md.

MOTHER
14. Maiden Name Mary E. Cottman
15. Birthplace Somerset Co., Md.

16 (a) Informant Miss Verna O. Webb
(b) Address 2930 Guilford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/9/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUN 6 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 5 1947 19 , at 9.A.M

21. I certify that death occurred on the date above stated; that I attended deceased from APRIL 25 1946 to JUNE 5 1947, and that I last saw h IM alive on JUNE 5 19 47

Immediate cause of death	Duration
CHRONIC MYOCARDITIS APRIL 25	1946.
Due to ARTERIOR SCLEROSIS	1946
Due to	
Other Conditions SENILITY.	

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation: NONE
of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr. Edward P. Chantrice M.D.
Address 3013 ST PAUL STREET. Date signed JUNE 5 1947.

G52365

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G52365

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 Eutaw Place
(c) Hospital or institution: Twilight Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 916 Hollins St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SALLIE MURNAGHAN

3 (b) If veteran, name war: --

3 (c) Social Security Account No.: --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife: -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 1871

8. AGE: Years	Months	Days	If less than one day
76	2	?	hr. min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation -
11. Industry or business

FATHER
12. Name Patrick Murnaghan
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary McArdle
15. Birthplace Ireland

16 (a) Informant Mrs. Ella Murnaghan
(b) Address 2647 Harlem Ave.

17 (a) Burial (b) Date thereof 6/ /47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director M. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUN 6 - 19 [illegible] Registrar
(Date rec'd by registrar)

V S 190

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5, 1947, at 8 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1947 to June 5 1947, and that I last saw her alive on June 4 1947.

Immediate cause of death	Duration
Broncho-pneumonia	10 days
Due to Cardio-vascular-hyper tensive disease	5 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Homer A. Todd M.D.
Address 2108 St Paul St. Date signed 6/6/47

G52366 — BALTIMORE CITY HEALTH DEPARTMENT — G52366

CERTIFICATE OF DEATH

83c

GM 97807 — Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 5 - 21
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. NO Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME King, George

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 24 -1882

8. AGE: Years	Months	Days	If less than one day
64	9	8	hr. min.

9. Birthplace MD.
(Town, county, and state)

10. Usual Occupation Huckster

11. Industry or business

FATHER
12. Name John King
13. Birthplace MD.

MOTHER
14. Maiden Name Mary Hagen
15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 7-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Belair Rd.

18 (a) Funeral director John F. Miller
(b) Address 2334 Jefferson St.

19 (a) [illegible] (Date received by Registrar) 6 1947 (b) Huntington Williams, M.D. Address

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 - 1947, at 12.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 11 1945 to June 2 1947, and that I last saw him alive on June 2 1947

Immediate cause of death	Duration
1. Respiratory failure	3 min.
Due to arteriosclerosis	
Due to	
Other Conditions Encephalomalacia, R. Occ.	

(Includes pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: June 3, 1947

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Julius Stadt, Jr. M. D.
Address Baltimore, Md. Date signed 6/3/47

VS 150

97

G52367

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157D

G52367 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 H
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1414 Decatur St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Claudia June Furman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4th 1946

8. AGE: Years	Months	Days	If less than one day
0	7	10	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Furman
13. Birthplace Baltimore

MOTHER
14. Maiden Name Evelyn Tornello
15. Birthplace Baltimore

16 (a) Informant George Furman
(b) Address 1414 Decatur St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/7/47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem
Location A. A. County

18 (a) Funeral director Charles F. Hill
(b) Address 1546 E. Fort Ave.

19 (a) JUN 6 - 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/4 1947, at 2 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1947 to June 4, 1947, and that I last saw h.e.r alive on 6/4 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Pneumonia - Encephalogram	
Due to	9 days
Other Conditions Blindness,	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene L. Gedalecia M. D.
Address Sinai Hospital Date signed

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52368 GM 110670

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1147

Registered No. G52368

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 19 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 418 N. Durham ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Platt, George Joseph

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 13 1913

8. AGE: Years	Months	Days	If less than one day
34	4	20	hr. min.

9. Birthplace SC. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name David Platt
13. Birthplace S.C.

MOTHER
14. Maiden Name Mattie
15. Birthplace S.C.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/7/47 (month) (day) (year)
(c) Cemetery or crematory Dulaney Valley
Location

18 (a) Funeral director Elroy A. Fuller
(b) Address 1000 Brantley Ave.

19 JUN 6 1947 (b) Washington Millington, M.D. Registrar
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 - 1947, at 11.29A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 - 1947 to June 3 - 1947 and that I last saw him alive on June 3- 1947

Immediate cause of death: Ventricular Fibrillation during operation (Pneumonectomy) — Duration

Due to

Due to

Other Conditions Lung Abscess

(Include pregnancy within 3 months of death)

Date of operation June 3, 1947

Major findings of operation: Lung Abscess (Right)

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice M. Lacy, M.D. M. D.
Address Baltimore City Hosp. Date signed June 7, 1947

X

G52369

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V93E

Registered No. G52369

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 610 S. Ellwood av
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 610 S. Ellwood av
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John. F. Dunnigan

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife India a.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2-1865

8. AGE: Years	Months	Days	If less than one day
82	2	3	hr. min.

9. Birthplace Harford Co. Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER 12. Name Edward Dunnigan
13. Birthplace Ireland

MOTHER 14. Maiden Name Bridget Fitzpatrick
15. Birthplace Ireland

16. (a) Informant Joseph Caldwell Dunnigan
(b) Address 610 S. Ellwood av

17 (a) Burial (b) Date thereof June 9-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Bath
Location Old Frederick Rd.

18 (a) Funeral director Thos. E. Hudson
(b) Address 3000 E. Baltimore St.

19 JUN 6 - 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 — 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 18 1946 to June 5 1947; and that I last saw h[im] alive on June 3 1947:

Immediate cause of death	Duration
Acute Cardiac Failure	
Due to Cardiac Decompensation	
Due to Myocarditis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E A Flanigan M.D.
Address 3503 Fair av Date signed June 6/47

V S 150

X

G52370

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V126

Registered No. G52370

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address M Calvert St.
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 155 S. Robinson (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Virginia Bognanni

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	Single

6 (b) Name of husband or wife /

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 27 1877

8. AGE: Years	Months	Days	If less than one day
70	4	8	hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Michael Battaglia of PETRALIA

13. Birthplace Italy

MOTHER 14. Maiden Name Pauline Pesora

15. Birthplace Italy

16 (a) Informant Grandaughter

(b) Address

17 (a) Burial (b) Date thereof 6/9/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director C. E. SCHIMMEL

(b) Address 2601 E. MADISON ST.

19 (Filed by registrar) JUN 6 - 1947 Washington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-4 1947 at 10:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 26 1947 to 6-4 1947 and that I last saw h.. alive on June 4 1947

Immediate cause of death	Duration
Cardiac Failure & Uremia	
Due to	
Due to	
Other Conditions Cholecystotomy & Appendectomy May 27 (Include pregnancy within 3 months of death)	
Date of operation May 27	
Major findings of operation: Chronic Cholecystitis & Cholelithiasis	
of autopsy:	

PHYSICIAN
Underline the cause of death which should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lawrence C. Thos M. D.

Address Mercy Hosp Date signed 6-7-47

VS 150

X

G52371

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 49a

Registered No. G52371

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3406 Dupont Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3406 Dupont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Theresa Pastore

3 (b) If veteran, name war: none

3 (c) Social Security Account No.:

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband: Vito Pastore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30 1888

8. AGE: Years 59 | Months | Days 6 | If less than one day hr. min.

9. Birthplace Castrogiovanni Italy
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Giuseppe Seita
13. Birthplace Italy

MOTHER
14. Maiden Name Anna?
15. Birthplace Italy

16 (a) Informant Vito Pastore
(b) Address 3406 Dupont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 7 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Pauld Della Rocca
(b) Address 52 N. Morley St.

19 JUN 6 - 1947 Huntington Williams MD
(Date rec'd by Registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/5 1947, at 6:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1940 to 6/5 1947 and that I last saw him alive on 6/4/1947

Immediate cause of death: Carcinomatosis Generalized — Duration 6 mos.

Due to — Duration owed

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation Exploratory Laparotomy

Major findings of operation: Malignant Mucoid Adenoma Ca.

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. T. Gattuso M.D.
M. D.

Address 5829 Belair Rd. Date signed 6/6/47

X

G52372

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BC#B-19662 1/68

Registered No. G52372

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 112 N. Gilmor St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 112 N. Gilmor St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Butler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/30/47

8. AGE: Years	Months	Days	If less than one day
			12 hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School JUN 5 1946
Commissioner of Health

18 (a) Funeral director

(b) Address

JUN 6 - 1947 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1947, at 3 P.M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Lib death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Strangulation

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-30- 19 47 at a.M.
(b) Where did injury occur? 112 N. Gilmor St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Bi-manual

23. Signature Howard J. Melvin M.D.
Medical Examiner.
Date signed 5/31-47

G52373

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V183

G52373 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 25-
(c) Hospital or institution: South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3326 Lake St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Horace Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
47			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School JUN 5 1946 Commissioner of Health

18 (a) Funeral director

(b) Address

19 JUN 6 - 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1947, at 6 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 5-19-47 at 4:30 P M.

(b) Where did injury occur? Arundel Cove

(c) Did injury occur at home, on farm, industrial place, in public place? Indust. Place While at work? no

(d) Means of injury Drowning in Patapsco River

23. Signature [illegible] M.D. Medical Examiner

Date signed 5-20-47

VS 181

G52374

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 46 E

G52374 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cost of age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2301 W Lanvale St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2301 W Lanvale St (If rural give location)
(e) Citizen of foreign country? Md (Yes or No) If yes, name country

3 (a) FULL NAME Clarice B Pelton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife John R Pelton

6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) Oct 18-1915

8. AGE: Years 31 | Months 7 | Days 6 | If less than one day hr. min.

9. Birthplace Lawrence Georgia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Ralph E Burkholder

13. Birthplace Virginia

MOTHER 14. Maiden Name Essie Oppenheimer

15. Birthplace Charleston S.C.

16 (a) Informant J. R. Pelton

(b) Address 2301 W Lanvale St

17 (a) Burial (b) Date thereof June 7 1947 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cemetery

Location

18 (a) Funeral director Chas S Howell

(b) Address 2427 Edmondson Ave

19 (a) 6 JUN 1947 (Date rec'd by registrar) (b) Registrar Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/4 1947, at 4 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 31 1947 to June 4 1947. and that I last saw h/w alive on June 4 1947.

Immediate cause of death: Carcinoma of whole uterus and ovaries — Duration 5 hrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Grant H Lahr M.D.

Address 1731 Pgh St Date signed 6/6/47

X

G52375

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G52375 No. 156a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The coroner's age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Herman Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 72 days
(e) Length of stay in Baltimore (yrs., mos., or days) 72 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County a a
(c) City or town Edgewater
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Jones

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife 0
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19, 1932

8. AGE: Years	Months	Days	If less than one day
15	3	18 17	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Student
11. Industry or business

FATHER
12. Name James H. Jones
13. Birthplace Maryland

MOTHER
14. Maiden Name Kathleen Fowler
15. Birthplace Maryland

16 (a) Informant Mattie H Taylor
(b) Address Edgewater md

17 (a) Burial Co (Burial, cremation, or removal) (b) Date thereof June 6 1947 (month) (day) (year)
(c) Cemetery or crematory
Location Annapolis Md

18 (a) Funeral director B L Hopkins & Bro
(b) Address Annapolis Md

6-6-1947 (Date rec'd by registrar) (Registrar)

Huntington Williams MD

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6, 1947, at 12-40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1947 to June 6 1947, and that I last saw h[illegible] alive on June 6 1947

Immediate cause of death: Acute dilatation of Stomach — Duration 30 min.

Due to: Post-operative Complications

Due to:

Other Conditions: Anthylosis of jaws

(Include pregnancy within 3 months of death)

Date of operation June 6, 1947

Major findings of operation: Anthylosed right temporo-mandibular joint

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature LB Thompson

Address Herman Hospital Date signed 6-6-47 M. D.

X

652376

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 652376

161a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Hard.
(c) City or town Hancock
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Donald P. Powers

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-2-47

8. AGE: Years | Months | Days 5 | If less than one day ____ hr. ____ min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Donald Powers
13. Birthplace Md

MOTHER 14. Maiden Name Daisy Barnhardt
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory St. Paul's
Location Clearspring Md.

18 (a) Funeral director Undertaker & Boyland
(b) Address Hagerstown Md.

19 JUN 7 - 1947 (Date rec'd by registrar) (b) Hagerstown, Washington, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/6/47 19___, at ___ M

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1947 to June 6 1947; and that I last saw h alive on June 6 1947

Immediate cause of death: cardiac failure — Duration: ____
Due to: Partial atelectasis congenital — Duration: ____
Due to: ____ — Duration: ____
Other Conditions: Dehydration — Duration: ____
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Partial atelectasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at ___ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alfred Ballach M. D.
Address Date signed

VS 190

C52377

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. C52377

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly. Supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 8
(d) Length of stay in hospital or inst. (~~yrs., mos.,~~ or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 7

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Balto. City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3213 Cliftmont Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Oberender (John Nicholas Oberender)

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: NONE

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Antoinette Oberender

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) MAR. 26, 1881

8. AGE: Years 66 | Months 2 | Days 9 | If less than one day ____ hr. ____ min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Baker

11. Industry or business

FATHER
12. Name John Oberender
13. Birthplace Germany

MOTHER
14. Maiden Name Anna ?
15. Birthplace Germany

16 (a) Informant John Oberender
(b) Address 3213 Cliftmont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 | 7 | 47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location BALTIMORE, MARYLAND

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE & BROADWAY

19 (a) JUN 7 - 1947 (Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 1947, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 29 1947 to June 4 1947 and that I last saw h[illegible] alive on June 4 1947

	Duration
Immediate cause of death: Cardiac & Resp Failure	
Due to: Carcinoma Colon & Metastases Prob. to Brain	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation June 2 1947

Major findings of operation: Carcinoma Colon & Metastases

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John E. Esnard, M. D.
Address Univ. Hosp. Date signed 6/4/47

VS 150

G52378

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131 B

Registered No. G52378

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1410 William St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1410 William St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gustave Miller

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-01-6891

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	Widower

6 (b) Name of husband or wife Anna Miller (nee Lattau)
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb. 18, 1882

8. AGE: Years	Months	Days	If less than one day
65	3	17	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Retired Clerical
11. Industry or business Supervisor for Butler Bros.

FATHER
12. Name ? Mills
13. Birthplace Md.

MOTHER
14. Maiden Name Mary E. Zylk
15. Birthplace St. Louis, Mo.

16 (a) Informant Mrs. Margaret C. Steinbock
(b) Address 1410 William St., Balto. 30, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 9, 1947
(month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director A. Howard Brown
(b) Address 1402 S. Charles St. Balto. 30, Md.

19 (a) JUN 7 - 1947 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5, 1947 at 11:45 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 3 1947 to June 5 1947, and that I last saw h[illegible] alive on June 5 1947.

Immediate cause of death Chronic Nephritis

Due to

Due to

Other Conditions Cerebral Sclerosis - Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature John C. Schmuck
Address 1337 S. Charles St. Date signed 6/6/47

V S 190

93D

G52379

BALTIMORE CITY HEALTH DEPARTMENT

BC# F87926 CERTIFICATE OF DEATH V 157E

Registered No. G52379

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Layzer & Dukeland
(c) Hospital or institution West Baltimore Gen Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2722 Cylburn Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Brenda Katz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct, 29, 1943

8. AGE: Years 3 | Months 7 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER 12. Name Jerry Katz
13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Florence Chomet
15. Birthplace Baltimore Md

16 (a) Informant Jerry Katz
(b) Address 2722 Cylburn Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 8, 1947 (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew Cem
Location Belair Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 JUN 7 - 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 June 1947, at 2:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 29 May 1947 to 6 June 1947, and that I last saw her alive on 6 June 1947

Immediate cause of death	Duration
Cardiac Failure	
Due to Heart, congenital malformation of	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lester A. Hall Jr. M. D.
Address Johns Hopkins Hosp Date signed 6/7/47

VS 150

Howard J. Wessler, M.D. X

052380

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 94a

Registered No. 052380

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2214 W. North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2214 W. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CATHERINE AGNES KNELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Frank J. Knell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 4, 1873

8. AGE: Years	Months	Days	If less than one day
73	8	1	hr. min.

9. Birthplace England
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Patrick Meehan
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Eagan
15. Birthplace Ireland

16 (a) Informant Mr. Frank J. Knell
(b) Address 2214 W. North Ave.

17 (a) Burial (b) Date thereof 6/9/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

JUN 7 - 1947 (Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5, 1947, at 7:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1947 to June 5 1947 and that I last saw her alive on June 5 1947

Cause of death	Duration
Immediate cause of death: Coronary occlusion	15 min
Due to: Arteriosclerosis	? years
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. Wallace Stewart M.D.
Address Maryland General Hosp. Date signed 6/6/47

V S 150

#G52381

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

Registered # G52381

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1367 N. Calhoun St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1367 N. Calhoun St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Frederick E. Bundy (Bundick)

3 (b) If veteran, name war: W W 1

3 (c) Social Security Account No.: ?

4. Sex: m | 5. Color or race: c | 6 (a) Single, married, widowed, or divorced: m

6 (b) Name of husband or wife: Florence

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 3 | 24 | 1898

8. AGE: Years: 49 | Months: 2 | Days: 10 | If less than one day: hr. min.

9. Birthplace: md (Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER — 12. Name: Rev. Carol Bundick

13. Birthplace: md

MOTHER — 14. Maiden Name: Layna Paulson

15. Birthplace: md

16 (a) Informant: Florence Bundick

(b) Address: 1367 N. Calhoun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 6 | 7 | 47 (month | day | year)

(c) Cemetery or crematory: Mt. Auburn

Location: Md

18 (a) Funeral director: Geo. H. Nelson

(b) Address: 1303 Pennsylvania Ave

19 JUN 7 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3 June 1947 19 , at 5:30a M

21. I certify that death occurred on the date above stated; that I attended deceased from 2 May 1947 to 3 June 1947, and that I last saw him alive on 2 June 1947.

Immediate cause of death: Aortic Insufficency — Duration: 3 mo.

Due to: Arterio-sclerosis — 3 yrs.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Wilbur D. Polk M. D.

Address: 1506 Penna. Ave. Date signed: 6-3-47

X

G52382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1218

Registered No. G52382

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2125 Division St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2125 Division (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Carr Woodland Hueston

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife. Alfred Hueston
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct. 27, 1912

8. AGE: Years	Months	Days	If less than one day
34	7	10	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Carr
13. Birthplace Eastern Shore, Md.

MOTHER
14. Maiden Name Effie Dyson
15. Birthplace Eastern Shore, Md.

16 (a) Informant Thomas Carr
(b) Address 2318 Etting St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/9/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary md
Location
18 (a) Funeral director Wes. H. Kelly
(b) Address 1303 Eutaw St
19 (a) Filed June 9 1947 (b) Washington Hollins, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6, 1947 19 at 1 P M
21. I certify that death occurred on the date above stated; that I attended deceased from March 27 1947 to June 6 1947 and that I last saw her alive on June 5 1947

Immediate cause of death	Duration
Pulminary Tuberculosis	1
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geary MacDonald M. D.
Address 844 N. Carey St. Date signed June 7 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully recorded. Do not abbreviate. Write the causes of death clearly and legibly. Physicians: please write the correct age in years, months, days, hours, or minutes. Exact age is especially important.

VS 150

C52383

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. C52383

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — Baltimore, Md.
(b) Street address 3217 Cliftmont Ave
(c) Hospital or institution: Died in his home
(d) Length of stay in hospital or inst. (yrs., mos., or days) X
(e) Length of stay in Baltimore (yrs., mos., or days) all life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3217 Cliftmont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas J. Kelly

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 218-69-9325

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife: Grace E.

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 9/19/84 1863

8. AGE: Years	Months	Days	If less than one day
82	8	16	hr. ____ min.

9. Birthplace Baltimore City (Town, county, and state)

10. Usual Occupation Cider

11. Industry or business none

FATHER
12. Name Do not know
13. Birthplace Ireland

MOTHER
14. Maiden Name Do not know
15. Birthplace Ireland

16 (a) Informant Mary Seitz (Daughter)
(b) Address 3217 Cliftmont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 9/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Breedin Rd

18 (a) Funeral director Geo. McGinnis & Son
(b) Address 811 N. Wolfe St

19 JUN 7 - 1947 (Date rec'd by Registrar) (b) Huntington Ave Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5 1947 at 6:25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to June 5 1947 and that I last saw him alive on June 5 1947.

Immediate cause of death: Coronary occlusion

Due to: Arterio-Sclerosis

Due to: Chronic Nephritis

Other Conditions: Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Martin A. Goodman M. D.

Address 3001 Seamon Drive

Date signed June 6-47

G52384

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 146E

G52384 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1615 Belt St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1615 Belt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Benjamin T. Everaman

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-01-0285

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Martha G. Everaman (nee Tucker) 6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) June 19, 1885

8. AGE: Years	Months	Days	If less than one day
61	11	18	hr. min.

9. Birthplace Nicomico Co., Md. (Town, county and state)
10. Usual Occupation Produce Commission Salesman
11. Industry or business For A. Burke & Co.

FATHER
12. Name James Everaman
13. Birthplace Md.

MOTHER
14. Maiden Name Eliza Ann Lloyd
15. Birthplace Md.

16 (a) Informant Mrs. Bertha G. Everaman (Wife)
(b) Address 1615 Belt St., Balto. 30, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 19 1947 (month) (day) (year)
(c) Cemetery or crematory London Park Cem.
Location Balto., Md.

18 (a) Funeral director G. Howard Evans
(b) Address 1400 S. Charles St., Balto. 30, Md

19 (a) JUN 7 1947 (b) [illegible]

V S 150

MEDICAL CERTIFICATION 5:45

20. DATE OF DEATH June 7, 1947 at A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 19 47 to 6/5 19 47. and that I last saw him alive on 6/5 19 47.

Immediate cause of death
Carcinoma of Large Intestine
Due to Mth metastasis to Liver
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

Duration
3 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. J. Ellison

Address 107 E. West Date signed M. 6/7/47 D.

X

G52385

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G52385

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town St Louis
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5606 Kingshighway
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia Zimmer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-30-21

8. AGE: Years 17 | Months 5 | Days 7 | If less than one day hr. min.

9. Birthplace MO.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edgar Herbert Zimmer
13. Birthplace

MOTHER
14. Maiden Name Emma Elizabeth
15. Birthplace

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 7 47 (month) (day) (year)
(c) Cemetery or crematory
Location St. Louis - Mo.

18 (a) Funeral director John O Mitchell & Sons
(b) Address 1900 Eutaw Pl.

19 (a) JUN 7 1947 (Registrar) (b) Huntington Williams, M.D.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 1947, at 1:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1947 to June 6 1947 and that I last saw h.er alive on June 6 1947.

Immediate cause of death: Congenital heart disease — Duration: Life

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Helen B. Kennedy
Address Johns Hopkins Hospital Date signed 6/6/47

X

G52386 BH#B-54613 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH √119a Registered No. G52386

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Typewrite or write the causes of death clearly and legibly. Physicians: please write correct age in months especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5½
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1104 Law St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Barry Dorsey George Sheppard Jr.d
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 8-25-46
8. AGE: Years | Months: 9 | Days: 9 | If less than one day hr. min.
9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Geo. Sheppard
13. Birthplace Md
MOTHER 14. Maiden Name Jean Dorsey
15. Birthplace Pa.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 7, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cem.
Location Brooklyn Md
18 (a) Funeral director Chas O. Wilson
(b) Address 1100 Bridadley ave
19 (a) (Signature of local registrar) (b) Huntington Williams M.D.
JUN 7 1947
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1947 at 3:50 P M
21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1947 to June 3 1947 and that I last saw him alive on June 3 1947.

Immediate cause of death	Duration
Bronchopneumonia	
Acute Staphylococcal Septicemia	5 days
Due to Skin Infection	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature L. Rosenquist M. D.
Address Johns Hopkins Hosp. Date signed

X

G52387

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G52387 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct... are especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1461 WASHINGTON Blvd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1461 WASH BLVD
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VINCENT T NOTO

3 (b) If veteran, name war: MERCHANT MARINES.
3 (c) Social Security Account No. 216-16-9959

4. Sex: MALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB-20-1923

8. AGE: Years	Months	Days	If less than one day
24	3	14	hr. min.

9. Birthplace BALTO MD
(Town, county, and state)
10. Usual Occupation LABORATORY.
11. Industry or business CALVERT DIST.

FATHER
12. Name VINCENT NOTO
13. Birthplace BALTO MD.

MOTHER
14. Maiden Name MARY KUCINSKI
15. Birthplace PA.

16 (a) Informant VINCENT NOTO
(b) Address 1461 WASH BLVD

17 (a) BURIAL (b) Date thereof JUNE 9-4
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location BALTO MD

18 (a) Funeral director Bernard G. Hartle
(b) Address 121 E. West St

JUN 8 - 1947
(Date rec'd by registrar) [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 6 1947, at 1.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 31 1947 to 6/6 1947, and that I last saw h[illegible] alive on 6/6 1947.

Immediate cause of death: Pulmonary Tuberculosis (Gave advanced) — Duration: 5 years
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Julian P. Urbick, Jr. M.D.
Address 1227 Wash. Blvd Date signed 6/6/47

X

G52388

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

Registration No. G52388

G52388

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cause to be especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State D.C. (b) County
(c) City or town Washington
(If outside city or town limits, write RURAL and give town)
(d) Street No. 825 49 2 St. NE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward McNichols

3 (b) If veteran, name war

3 (c) Social Security Account No. 579-01-057

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7th 1904

8. AGE: Years 43 | Months | Days | If less than one day hr. min.

9. Birthplace Annapolis Md.
(Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business State Cleaner Dept.

FATHER 12. Name Benj. Mc. Nichols

13. Birthplace Unknown-

MOTHER 14. Maiden Name Emma Price

15. Birthplace Richmond Va.

16 (a) Informant Emma Nichols

(b) Address 512 S. Green St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 6 8 47 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cemetery

Location Balto. Md.

18 (a) Funeral director Walter D. Spriggs

(b) Address 1999 W. Hamburg St.

19 (a) (Date rec'd by registrar) (b) Registrar

6-8-1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/5 1947, at 2:25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive cardiovascular disease

Due to

Other Conditions Coronary disease

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Chester J. Lubinski, M.D. M.D.
Medical Examiner.

Date signed 6-5-47

VS 121

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52389 G52389

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 150

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3218 Mondawmin Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3218 Mondawmin Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Esther Plotkin

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-05-1146

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Morris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1908

8. AGE: Years	Months	Days	If less than one day
38	10	30	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business House Work

FATHER
12. Name Nathan Blinken
13. Birthplace Russia

MOTHER
14. Maiden Name Blanche Dzikovsky
15. Birthplace Russia

16 (a) Informant Morris Plotkin
(b) Address 3218 Mondawmin Ave

17 (a) Burial (b) Date thereof June 8, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave
18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave
(Date received by Registrar) (b) Signature of Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 1947, at 2 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 15 1947 to June 8 1947 and that I last saw her alive on June 6 1947

Immediate cause of death carcinomatosis — Duration 2 Months
Due to carcinoma, metastatic, Left breast — 6 Months
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nathan Rosen
Address 206 S. Gilmor St. Date signed M 6 D 7 47

X

G52390

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G52390

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The date of death is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Levendale Home
(b) Street address Belevedere & Greenspring Ave
(c) Hospital or institution: Levindale
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4023 W Garrison Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Micholsky

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	W

6 (b) Name of husband or wife Late Michael
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1862

8. AGE: Years	Months	Days	If less than one day
85			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business None

FATHER
12. Name Unkown
13. Birthplace Russia

MOTHER
14. Maiden Name Unkown
15. Birthplace Russia

16 (a) Informant Joseph Klein
(b) Address 4023 W Garrison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 8, 1947 (month) (day) (year)
(c) Cemetery or crematory Hebrew Washington Road
Location Washington Blvd

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-7 1947, at 11P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-23 1932 to 6-7 1947, and that I last saw h[illegible] alive on 6-7 1947

Immediate cause of death	Duration
Cerebral Hemorrhage	
Hypertension	
Arteriosclerosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Edmund Levin
Address Levindale Date signed 6/7/47

1947

X

Md 652391

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G52391 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3309 Liberty Heights Ave
(c) Hospital or institution: Apt. # 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3309 Liberty Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry C. Inensel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mae E. Inensel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 21-1880

8. AGE: Years	Months	Days	If less than one day
66	9	16 15	hr. min.

9. Birthplace Washington D. C.
(Town, county, and state)
10. Usual Occupation Investory Clerk
11. Industry or business

FATHER
12. Name Cornelius Inensel
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Otter
15. Birthplace Baltimore Md

16 (a) Informant Mae E. Inensel Wife
(b) Address 3309 Liberty Heights

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 8-1947 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem
Location Baltimore Md

18 (a) Funeral director Jennie E. Syfer
(b) Address 1606 W. North Ave

19 (a) (Date rec'd by registrar) (b) Registrar

JUN 8 - 1947

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5 1947, at 7-25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1947 to June 5 1947 and that I last saw h.. alive on June 5 1947

Immediate cause of death: cardiac arrest. — Duration 3 hrs.

Due to Hypertension — 5 yrs.

Due to Cerebral Hemorrhage C.V.D. & Lung — 8 hrs. 3 hrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. W. Kemp M. D.

Address 120 E. Saratoga St Date signed 6/6/47

X

G52392

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 157E

G52392 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Lorraine Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Havre de Grace (If outside city or town limits, write RURAL and give town)
(d) Street No. 732 Ontario St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harry J. Lehfield Jr.

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1946

8. AGE: Years 0 | Months 6 | Days 11 & 10 | If less than one day — hr. — min.

9. Birthplace Havre de Grace Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Harry J. Lehfield Sr.
13. Birthplace West Va.

MOTHER
14. Maiden Name Monita Emery
15. Birthplace Georgia

16 (a) Informant Mother Mrs. Monita Schofield
(b) Address Same Havre de Grace, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 11 1947 (month) (day) (year)
(c) Cemetery or crematory
Location Montezuma Ga.

18 (a) Funeral director R. Madison Mitchell
(b) Address Havre de Grace, Md.

[illegible] 8 - 1947 (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 1947, at 3:05 AM
21. I certify that death occurred on the date above stated; that I attended deceased from 6-7 1947 to 6-8 1947 and that I last saw him alive on 6-8 1947.

Immediate cause of death: Respiratory Failure — Duration: 5 min.
Due to: Pneumonia + atelectasis — 1 day
Due to: Fatty Congested Heart Lesion — 6 mos.
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
At autopsy: Same

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William D. Gentry M. D.
Address Mercy Hosp Date signed 6-9-47

PHYSICIAN
Underline the cause to which death should be charged statistically.

VS 150

G52393
511482

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G52393
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla (b) County.....
(c) City or town Sanford
(If outside city or town limits, write RURAL and give town)
(d) Street No. 811 Palmetto Ave.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Ethel W. Root

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Rev. J. Barnard.
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) 11-12-1899.

8. AGE: Years	Months	Days	If less than one day
47	6	25	hr. ..... min.

9. Birthplace Waltham (Mass.) Mass.
(Town, county, and state)
10. Usual Occupation Home Wife
11. Industry or business

FATHER
12. Name Amanda Whitmore
13. Birthplace Ill.

MOTHER
14. Maiden Name Gamma Barnard.
15. Birthplace Mass.

16 (a) Informant Rhoda.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 6/9/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Waltham
Location Mass.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st.

(a) Registered by registrar 8 1947 (b) [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7 1947, at 2:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 11 1947, to June 7 1947, and that I last saw him alive on June 7 1947.

Immediate cause of death Carcinomatosis	Duration
Due to Carcinoma, Left ovary	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at ..... M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work?
(Specify type of place)
(e) Means of injury.....

23. Signature [illegible] M.D.
Address Johns Hopkins Hosp. Date signed 6-7-47

G52394

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G52394 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cause of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Put age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6022 Old Harford Rd
(c) Hospital or institution: Brook Hill Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5507 York Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cecile A. Wildman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or ~~wife~~: Eugene Wildman
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov 27th 1895
8. AGE: Years 51 | Months 6 | Days 9 | If less than one day hr. min.
9. Birthplace Chicago Ill (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business at Home

FATHER
12. Name Louis Krenik
13. Birthplace Vienna

MOTHER
14. Maiden Name Christine (Unknown)
15. Birthplace Vienna

16 (a) Informant Eugene Wildman
(b) Address 5507 York Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/9/47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st

19 (a) (Registrar's signature) (b)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6th 1947, at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1947 to June 6 1947 and that I last saw h.e alive on June 6 1947.

Immediate cause of death Carcinoma of Cervix with metastases — Duration 2 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation June 2 1947

Major findings of operation: Chordotomy for intractable pain

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A.S. Chaffee M. D.
Address 5210 York Rd Date signed June 7 47

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G52395 Registered No. G52395

G52395 V46E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Ave.
(c) Hospital or institution: St. Agnes Hospital 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21da
(e) Length of stay in Baltimore (yrs., mos., or days) 29yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Balto City
(If outside city or town limits, write RURAL and give town)
(d) Street No. Seton Institute
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rev. Modest Parolini (REV. MODESTO PAROLINI)
3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	single

6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 18 1876

8. AGE: Years	Months	Days	If less than one day
70	6	19	hr. min.

9. Birthplace Austria (town, county, and state)
10. Usual Occupation Priest
11. Industry or business Religious

FATHER
12. Name Pomedio Parolini
13. Birthplace Tirol Austria

MOTHER
14. Maiden Name Crescentia Bonricini
15. Birthplace Tirol Austria

16 (a) Informant Seton Institute
(b) Address Baltimore
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-9-47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md
18 (a) Funeral director Stuart Morgan Co.
(b) Address 108 W. North Ave.
19 (a) JUN 8 1947 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-6 1947 at 5:35 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 5/16 1947 to 6/6 1947 and that I last saw h. alive on 6/6 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to	
Due to	
Other Conditions Adenocarcinoma of sigmoid colon (Include pregnancy within 3 months of death)	

Date of operation May 31, 1947
Major findings of operation: Carcinoma of colon
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature John C. Oppenheimer
Address St. Agnes Hosp. Date signed 6/6/47 M.D.

G52396

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G52396 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland - Rayner
(c) Hospital or institution: West Balto Gen Hosp 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 10 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3605 Forest Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pere Borow

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Moses Borow (Both)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace LITH.
(Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name NOT KNOWN
13. Birthplace LITH.

MOTHER
14. Maiden Name ROSE
15. Birthplace LITH.

16 (a) Informant HUSBAND
(b) Address

17 (a) BURIAL (b) Date thereof 6-8-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Windsor Mill Rd
Location Windsor Mill Road

18 (a) Funeral director JACK LEWIS INC
(b) Address 2100 EUTAW PL.

JUN 8 - 1947 (b)
Date of registration

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 1947, at 435 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 7 1947 to June 8 1947 and that I last saw her alive on June 8 1947

Immediate cause of death Acute Pulmonary edema — Duration 10 hours

Due to Hypertensive-arterio sclerotic heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Donald F Gleason M. D.
Address 2834 St Paul St Balto-Md Date signed June 8 47

X

G52397

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G52397 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cost of age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 507 Stuart Ave
(c) Hospital or institution: 2nd

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 507 Stuart Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rubin Shor

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sarah
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-15-1889

8. AGE: Years	Months	Days	If less than one day
58	2	23	hr. min.

9. Birthplace Russia (Town, county and state)
10. Usual Occupation merchant
11. Industry or business

FATHER
12. Name Hyman
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Sarah Shor
(b) Address 507 Stuart Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-8-47 (month) (day) (year)
(c) Cemetery or crematory United Hebrew
Location Washington Boulevard

18 (a) Funeral director Jack Lewis Inc
(b) Address 1416 Balto St.

JUN 8 - 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-7- 1947 at 3P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 15 1947 to June 7 1947.
and that I last saw h[illegible] alive on June 5 1947

Immediate cause of death	Duration
Coronary Arterial Sclerosis	3yrs
Due to:	
Due to	
Other Conditions Chron Cardiac Cyst	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature M D Jacobs Jr M.D.
Address 2040 Eutaw Pl Date signed 6/7/47

VS 150

G52398

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G52398

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3832 Dorman Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4417 Pimlico Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Pollack

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Abraham
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Israel
13. Birthplace Russia

MOTHER
14. Maiden Name Jaleg
15. Birthplace Russia

16 (a) Informant Mrs Leah Ough
(b) Address 4417 Pimlico Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-8-47 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Herzeng Cem

18 (a) Funeral director Lacy & Levy Inc
(b) Address 1529 E Balto St

19 (a) [illegible] (Registrar) Registrar

JUN 8 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-7- 1947, at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 26 1947 to June 7 1947, and that I last saw h[illegible] alive on June 7 1947.

Immediate cause of death	Duration
Congestive Heart Failure	
Due to Hypertension & CVD	
Due to	
Other Conditions Gen. Arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Harland Aspegren
Address 2511 Reisterstown Rd Date signed 6/9/47

VS 150

G52399

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G52399 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 97
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5510 Minoka Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isadore Tossman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Kate

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years 53 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER 12. Name Samuel
13. Birthplace Russia

MOTHER 14. Maiden Name Eva
15. Birthplace Russia

16 (a) Informant Kate Tossman
(b) Address 5510 Minoka Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-9-47 (month) (day) (year)

(c) Cemetery or crematory
Location Hebrew Mt. Carmel

18 (a) Funeral director Jack Lewis Inc
(b) 1947 1439 E Balto St

19 (a) (Date rec'd by registrar) Huntington Hollins Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 June 1947, at 3:10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4 June 1947 to 8 June 1947, and that I last saw him alive on 8 June 1947

Immediate cause of death	Duration
Heart failure	
Due to Acute coronary occlusion	
Due to	
Other Conditions Metastatic Ca of liver & spleen - primary site unknown	

(Include pregnancy within 3 months of death)

Date of operation 6 June 47

Major findings of operation: Miliary metastatic Ca of liver & spleen

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard H. Katz M. D.
Address Sinai Hospital Date signed 9 June 47

94a

G52100 G52400

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1422 N. Port St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1422 N. Port St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME August G. Miller

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Margaret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 1894

8. AGE: Years	Months	Days	If less than one day
52	7		hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Christian Miller
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Roemer
15. Birthplace Germany

16 (a) Informant Mrs Margaret Miller
(b) Address 1422 N Port St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-9-47 (month) (day) (year)
(c) Cemetery or crematory Sevarts Lane
Location Old Annapolis Rd

18 (a) Funeral director Leo B. Cook
(b) Address 1201-03 N. Patterson Park ave

19 (a) (Date rec'd by registrar) (b) Registrar

JUN 8 vs 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-5-47 at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 5 June 1947 to 6 June 1947, and that I last saw h. l. alive on 5 June 1947

Immediate cause of death: Coronary Thrombosis — Duration: 6 hours

Due to: Arteriosclerosis

Due to:

Other Conditions: Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.

Address 1543 N. Milton Ave Date signed 7 June 47

X

G52401

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1248

G52401 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1720 N. Port St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1720 N. Port St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Meninger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age 86 4 years

7. Birth date of deceased (mo., day, yr.) Feb 13th 1864

8. AGE: Years 83 | Months 3 | Days 21 | If less than one day: hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Meninger
13. Birthplace Germany

MOTHER
14. Maiden Name Katharine Dickenscheer
15. Birthplace Germany

16 (a) Informant Mrs Lena Welch
(b) Address 1720 N Port St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-9th 1947 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Road

18 (a) Funeral director Leo G. Leask
(b) Address 1303 N Patterson Park Ave

19 (a) (b) (Date received by registrar) Registrar

JUN 8 1947
Vs 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-6th 1947, at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1937 to 6/6 1947 and that I last saw h[illegible] alive on June 5 1947

Immediate cause of death: Ca Myocardium — Duration: 10 years
Due to: Coronary Thrombosis
Due to: Arterio Sclerosis Ch Hypertension
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. S. Sturdivant
Address 4810 Belair Rd Date signed 6/6/47

X

G52402

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46H

G52402 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 129 Willard Street
(c) Hospital or institution: No

(d) Length of stay in hospital or inst. (yrs., mos., or days) No
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 129 Willard St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles August Meyer

3 (b) If veteran, name war None

3 (c) Social Security Account No. 705-09-9048

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Jennie E. Meyer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 16 1872

8. AGE: Years 74 | Months 5 | Days 26 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Foreman (B+O)

11. Industry or business Retired

FATHER 12. Name John C. Meyer
13. Birthplace Germany

MOTHER 14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Jennie E. Meyer
(b) Address 129 Willard Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-9-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Maryland

18 (a) Funeral director George L. Seward
(b) Address 2101 Frederick Ave.

JUN 8 1947 (Date rec'd by registrar) (b) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6, 1947, at 1 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 15 1947 to June 6 1947 and that I last saw h— alive on June 5 1947.

Immediate cause of death	Duration
Cardiac Failure	
Due to Carcinoma of Liver	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation August 8 1947
Major findings of operation Carcinoma Ca Liver, Confirm
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Albert Seagroth M. D.
Address 1729 W Lombard St Date signed 6/6/47

G52403 BH 280496 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 159 G52403 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 33 S. Calhoun St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rebecca Rae Fankell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/6/47

8. AGE: Years | Months | Days | If less than one day: 7 hr. min.

9. Birthplace Balto, Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER — 12. Name Raymond Fankell
13. Birthplace Bullitton Kentucky

MOTHER — 14. Maiden Name Avonelle Burton
15. Birthplace Ohio

16 (a) Informant Mr Raymond Fankell
(b) Address 33 S. Calhoun St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-9-47 (month) (day) (year)
(c) Cemetery or crematory Scioto Funeral Co.
Location Scioto Furnace, Ohio

18 (a) Funeral director Fred T. Cole
(b) Address 12 [illegible] Lombard St
19 (a) (b) (Date received by Registrar)

JUN 8 - 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/7 19 47 at 5.50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/6 19 47 to 6/7 19 47. and that I last saw h[illegible] alive on 6/7 19 47.

Immediate cause of death	Duration
Prematurity	
Due to Premature labor with placental separation.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address St. Agnes Hosp. Date signed 6/8/47 M D

X

G52404

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1313

Registered No. G52404

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1500 Argyle Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Jefferson Hyman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Bessie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-5-1901

8. AGE: Years	Months	Days	If less than one day
45 46	11	-	hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Bessie Hyman
(b) Address 1500 Argyle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 9 47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore Md

18 (a) Funeral director William A Jackson
(b) Address 916 Penna Ave

19 JUN 9 - 1947 (Date rec'd by registrar) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5 1947, at 12 30 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pulmonary tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer, M.D. Howard J. Madison M.D. Medical Examiner.
Date signed 6-5-47

G52405

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1836

Registered No. G52405

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3732 Ramona Ave
(c) Hospital or institution: 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3732 Ramona Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Steiner.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Anna M Steiner

6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) Nov 8, 1872

8. AGE: Years 74 | Months 6 | Days 7 | If less than one day ____ hr. ____ min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business Retired

FATHER 12. Name Gottfried Steiner

13. Birthplace Germany

MOTHER 14. Maiden Name Antoinette Schneider

15. Birthplace Germany

16 (a) Informant Mrs Erna Rulbman

(b) Address 3732 Ramona Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 9 (month) (day) (year)

(c) Cemetery or crematory St Matthews Cem

Location City

18 (a) Funeral director Ulrich Funeral Home

(b) Address 2006 Orleans St

JUN 9 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5th 1947, at 12 25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-24- 1940, to 6-4- 1947, and that I last saw him alive on 6-4- 1947.

Immediate cause of death	Duration
Cerebral Thrombosis	4 days
Due to Generalised arterio-sclerosis	7 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nelson C Laug M. D.

Address 2117 Belair Rd Date signed 6-5-47

V S 150

X

C52106 BC# 980234

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √160a

Registered No. C52106

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens + Caton Ave.
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 620 Hendenson Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Simon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/5/47

8. AGE: Years | Months | Days | If less than one day: 17 hrs. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Jokob Velkind
13. Birthplace Md.

MOTHER — 14. Maiden Name Elizabeth Simon
15. Birthplace Md.

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-9-47 (month) (day) (year)

(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director George A Feeley
(b) Address Fulton Ave + Fayette St

19 JUN 9 - 1947 (Date rec'd by registrar) (b) Huntington Williamson Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/6 1947, at 2:25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/5 1947, to 6/6 1947 and that I last saw h/ he alive on 6/6 1947

Immediate cause of death: Cardiac failure — Duration
Intracranial hemorrhage

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D W Mintz M.D.
Address Stagers Date signed 6/7/47 M. D.

X

G52407.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V170D

Registered No. G52407.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
(a) Baltimore City, Maryland
(b) Street address Linden & Madeira
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Carroll
(c) City or town Eldersburg
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Edward Barnes

3 (b) If veteran, name war
3 (c) Social Security Account No.

4 Sex Male | 5 Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Louise Barnes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 26 1925

8. AGE: Years 21 | Months 9 | Days 12 | If less than one day hr. min.

9. Birthplace Carroll Co Maryland
(Town, county, and state)

10. Usual Occupation Laborer
11. Industry or business At Large

FATHER
12. Name Roby F. Barnes
13. Birthplace Maryland

MOTHER
14. Maiden Name Opal L. Shipley
15. Birthplace Maryland

16 (a) Informant Roby F. Barnes
(b) Address Eldersburg Maryland

17 (a) Burial (b) Date thereof 6/11/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Freedom Cem.
Location Gambler Maryland

18 (a) Funeral director H. Myers Inc
(b) Address Sykesville Maryland

19 JUN 9 - 1947 Westminster, Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 June 1947, at 5:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Cerebral Hemorrhage, Traumatic
Pulmonary Hemorrhage, Traumatic
Due to Fracture of skull, ribs.

Other Conditions Fracture, mandible, compound
Multiple abrasions.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6/5/47 at Baltimore 3:30 P.M.
(b) Where did injury occur? Oakland Ave & Liberty Rd
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Motorcycle into telegraph pole.

23. Signature Wm. H. Kammer, Jr. M.D.
Medical Examiner.
Date signed 9 June 1947

VS 131

G52108 BCH #80452 BALTIMORE CITY HEALTH DEPARTMENT G52108

CERTIFICATE OF DEATH V160a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address —
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 248 N Mount St
(If rural give location)
(e) Citizen of foreign country?, (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy SCHERR

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Wh	

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6 / June / 47

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Thomas Scherr
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Irene Zeied
15. Birthplace Baltimore Maryland

16 (a) Informant Thomas Scherr.
(b) Address 248 N. Mount St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-9-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phila Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Utah Place

JUN 9 1947 (Date) Registrar for Baltimore MD

YS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 / June / 47 1947 at 11:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6 / June 1947 to 8 / June 1947 and that I last saw h[illegible] alive on 8 / June / 1947

Immediate cause of death	Duration
Lacerated Cranial Hemorrhage	
Due to Birth Injury	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Stanley B. Klyanowicz
Address Franklin Sq. Hosp. Date signed 6/8/47

G52409

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G52409

The PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2836 Elliott St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2836 Elliott St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter Chronowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	widowed

6 (b) Name of husband or wife Mary Chronowski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27 1880

8. AGE: Years	Months	Days	If less than one day
66 67	11	15	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Walenty Chronowski
13. Birthplace Poland

MOTHER
14. Maiden Name ?
15. Birthplace Poland

16 (a) Informant Anna Antczak
(b) Address 2836 Elliott St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 10/47 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Dundalk Ave

18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson St

JUN 9 - 1947 (Date rec'd by Registrar) (b) Huntingtown Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-7-47 19 , at 2 30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1947 to 6-7 1947 and that I last saw h alive on 6-6-47 19

Immediate cause of death	Duration
Arteriosclerotic C-V Disease	
Chr Myocarditis	
Due to acute Coronary Thrombosis	from 2/47
acute coronary Occlusion	6-4-47
Due to	
Other Conditions Dead	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Kaschemeck M. D.
Address 842 S Eastern Date signed 6-9-47

V S 150

G52110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G52110

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 701 E. Fort Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 701 E. Fort Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander Doda

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Anna Doda
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years 54 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation

11. Industry or business Tavern owner

FATHER 12. Name ?
13. Birthplace Poland

MOTHER 14. Maiden Name ?
15. Birthplace Poland

16 (a) Informant Anna Doda
(b) Address 701 E. Fort Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 9 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Germantown Hill Rd.

18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson St.

19 (a) JUN 9 1947 (Date rec'd by Registrar) (b) Funeral Director for Address

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/5 1947, at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1946 to 1947, and that I last saw h[illegible] alive on 6/5 1947.

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to Hypertension and Cardio-Vascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. J. Strauss
Address 107 E. West St Date signed 6/7/47 M. D.

V S 150

CRUMPLER

G52411

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G52411

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 707 Pierce St.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 707 Pierce St.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Crumpler.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Jessie Crumpler
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 44, 1902

8. AGE: Years	Months	Days	If less than one day
44	8		hr. min.

9. Birthplace Fayetteville N. C.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Fuller.
13. Birthplace Fayetteville N.C.

MOTHER
14. Maiden Name Fannie Morgan.
15. Birthplace Fayetteville, N.C.

16 (a) Informant H. Langin Evans.
(b) Address 707 Pierce St.,

17 (a) Burial (b) Date thereof June 9, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) (b) Huntington Williams

JUN 9 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1947 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1947 to June 3 1947 and that I last saw h[illegible] alive on June 4 1947

Immediate cause of death Cardiac Renal — Duration 6 mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. L. Skyles
Address 1 W Pratt St Date signed 6/5/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

052412

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 052412

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4203 Groveland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4203 Groveland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leona M. DeBring

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-07-8343

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 1 1890

8. AGE: Years	Months	Days	If less than one day
57	4	7	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Clerk Statistic Dept

11. Industry or business US Fidelity & Guar. Co

FATHER
12. Name Anthony B. DeBring
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Regina M. Spies
15. Birthplace Baltimore Md

16 (a) Informant Mrs. J. D. Dixon
(b) Address 4203 Groveland Ave

17 (a) Burial (b) Date thereof June 11 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director Harry H. Thuneaer
(b) Address 4204 Ridgewood Ave

19 (Filed by registrar) JUN 9 - 1947 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 1947, at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1942 to June 8 1947, and that I last saw her alive on June 8 1947

Immediate cause of death	Duration
Coronary Occlusion	14 hrs.
Due to Arteria - Sclerosis	years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry Lee Hargrove M. D.
Address 715 E. Baltimore St Date signed 6/9/47

VS 150

G52413

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G52413

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2701 TIVOLY AVE
(c) Hospital or institution: 91
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2701 TIVOLY AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CHARLES SEIMON OTTO, SR.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife LOUISE (McCAULEY)
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) JULY 15, 1876

8. AGE: Years	Months	Days	If less than one day
70	10	23	hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation SUPT. CAN SHOP.
11. Industry or business

FATHER
12. Name SAM OTTO
13. Birthplace BALTIMORE, MD

MOTHER
14. Maiden Name ANNIE DAYTON
15. Birthplace EASTERN SHORE

16 (a) Informant EVA OTTO
(b) Address 2712 FENWICK AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 6 10 47 (month) (day) (year)
(c) Cemetery or crematory PARKWOOD.
Location TAYLOR AVE

18 (a) Funeral director JOHN F. DENNY, INC.
(b) Address 715 LIGHT ST.

19 (a) JUN 9 - 1947 (Filed by registrar) Registrar for Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 June 1947 at 7:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to June 1947 and that I last saw him alive on 7 June 1947

Immediate cause of death Cerebral Hemorrhage — Duration 3 Days

Due to Heart failure — 3 Days

Due to Arteriosclerosis — 5 Days

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address 2800 Hanover Ave Date signed June 8

VS 150

G52414

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G52414

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4617 Mannasota ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4617 Mannasota ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Pritacha
3 (b) If veteran, name war
3 (c) Social Security Account No. 213-09-9343

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 3 1893

8. AGE: Years 53 | Months 10 | Days 9 10 | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Shipping Clerk
11. Industry or business

FATHER
12. Name Ambrose Pritacha
13. Birthplace Balto

MOTHER
14. Maiden Name Helena Victorman
15. Birthplace Balto

16 (a) Informant Mrs Giles
(b) Address 4617 Mannasota

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 9-47 (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director Jos J Henston
(b) Address 3001 Kentucky ave Huntington W Virginia

19 (Signature and title) Registrar
(Date rec'd by registrar) JUN 9 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 1947, at 9 Pr M

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1947 to June 6 1947 and that I last saw h alive on 19

Immediate cause of death	Duration
Coronary heart disease	1 day
Due to	
Due to	
Other Conditions Epilepsy 45 yrs. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C Lee Thelen
Address 4116 Northern Parkway Date signed 6/7/47

VS 150 Embalmer's Report To be approved by Medical Examiner X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52115

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

G52115
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3107 Kentucky Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3107 Kentucky Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Martin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Florence

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 7-1877

8. AGE: Years 69 | Months 8 | Days 29 | If less than one day: hr. min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation Balto Transit

11. Industry or business

FATHER
12. Name Thomas Martin
13. Birthplace Balto

MOTHER
14. Maiden Name Helen Duley
15. Birthplace Balto

16 (a) Informant Mrs Florence Martin
(b) Address 3107 Kentucky Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 10-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director Jos J Kerr & Son
(b) Address 3001 Kentucky ave

19 Filed June 9 1947 Washington Williamson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 1947, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2 1947, to June 6 1947, and that I last saw h[illegible] alive on June 4 1947

Immediate cause of death: Carcinomatosis of kidney — Duration 3 yrs?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Feb. 1947

Major findings of operation: Carcinomatosis

Autopsy? Surgical Pathology

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Adams Johnson M. D.

Address 6232 Belair Road Date signed June 9, 1947

VS 150

X

G52416

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G52416 Registered No. 1316

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1100 Cajedine St.

(c) Hospital or institution: St Josephs Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3818 Southern Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mr. William F. Kelly.

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-07-7137

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Anna B. Kelly

6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) June 4- 1882.

8. AGE: Years 65 | Months 0 | Days 3 | If less than one day ____ hr. ____ min.

9. Birthplace Pa

(Town, county, and state)

10. Usual Occupation Engineer

11. Industry or business B & O. R. R

FATHER 12. Name Martin Kelly

13. Birthplace Pa

MOTHER 14. Maiden Name Unknown

15. Birthplace "

16 (a) Informant Anna B. Kelly

(b) Address 3818 Southern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 10-1947 (month) (day) (year)

(c) Cemetery or crematory Baltimore City

Location

18 (a) Funeral director Mr & Mrs. John W. Teufel & Son

(b) Address 5311 Edmondson Ave

19 (a) 1947 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7 1947, at 10 40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1947 to June 7 1947 and that I last saw him alive on June 7 1947.

Immediate cause of death	Duration
Coma - Carcinomatosis	
Due to Cardiac decompensation	
Due to Uremia, Chronic, Diffuse Glomerulonephritis	
Other Conditions and terminal pneumonia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Robert H. Young

Address St Josephs Hosp Date signed M. 6/7/47 D.

VS 190 1947

6-9-1947

G52117

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

G52117

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1110 W. Lafayette Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mich (b) County
(c) City or town Detroit
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2128 E. Congress St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cecilia M. Barnes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife John D. Barnes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 5, 1903

8. AGE: Years 43 | Months 9 | Days 3 | If less than one day hr. min.

9. Birthplace Detroit, Michigan
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Walter Harris
13. Birthplace Michigan

MOTHER
14. Maiden Name Grace Brown
15. Birthplace Canada

16 (a) Informant Rev. John D. Barnes
(b) Address 2128 E. Congress St. Detroit, Mich.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-11-47 (month) (day) (year)
(c) Cemetery or crematory Memorial Park
Location Detroit, Michigan

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) 9 1947 (b) Huntington Williams M.D.
(Signature of local registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 June 1947, at 12:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Edema, Acute

Due to Cardiac Decompensation

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer Jr. M.D.
Medical Examiner.

Date signed 9 June 1947

C52118

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 51 B

Registered No. C52118

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert St.
(c) Hospital or institution: Mercy Hosp Baltimore Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3907 Pinewood Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edwin E. Brown

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	~~single~~ widowed

6 (b) Name of husband or wife No
6 (c) If alive, give age No years

7. Birth date of deceased (mo., day, yr.) Feb 21 1874

8. AGE: Years	Months	Days	If less than one day
68	3	15	1 hr. 20 min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Ret Brown
11. Industry or business

MOTHER / FATHER
12. Name Albert L Brown
13. Birthplace Virginia
14. Maiden Name Anna M. Steigerwald
15. Birthplace Baltimore

16 (a) Informant Mrs. John Requardt
(b) Address 101 W. Overlea Ave., Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 12, 1947 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto., Md.

18 (a) Funeral director Lazenby Funeral Home
(b) Address 7401 Belair Road

JUN 9 - 1947 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-9 1947, at 1 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-5 1947 to 6-9 1947 and that I last saw him alive on 6-9 1947.

Immediate cause of death Hypertensive Cardio Vascular Disease — Duration

Due to

Due to

Other Conditions Prostatic Carcinoma (Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lawrence J. Kent M. D.
Address Mercy Hosp Date signed 6-9-47

VS 150

937

C52119

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

832a

Registered No. C52119

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 337 East 20th Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 337 East 20th Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANNIE W. WORMAN

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: John D.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 4, 1857

8. AGE: Years 89 | Months 9 | Days 3 | If less than one day: hr. min.

9. Birthplace Philadelphia, Penna. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own Home

FATHER
12. Name John Scott
13. Birthplace Phila. Penna.

MOTHER
14. Maiden Name Catherine DeForrest
15. Birthplace Phila. Penna.

16 (a) Informant Mrs. Agnes Andrade
(b) Address 337 East 20th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 10, 47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) JUN 9 - 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7 19 47 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 5 June 19 47, to 7 June 19 47, and that I last saw h Ex alive on 7 June 19 47

	Duration
Immediate cause of death: Cerebral hemorrhage	2 days
Due to: arteriosclerosis & hypertension	?
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Silverfield M. D.
Address 714 E. Preston Date signed 9 June 47

VS 150

G52120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G52120

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 804 N. Broadway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7.5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 804 N. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK J. EASTWOOD

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary Frances
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 13, 1862

8. AGE: Years	Months	Days	If less than one day
84	6	25	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual Occupation Grocer
11. Industry or business Retired

FATHER
12. Name Noel Eastwood
13. Birthplace England

MOTHER
14. Maiden Name Fredrica Studenwalt
15. Birthplace Germany

16 (a) Informant Mrs. Mary Frances Eastwood
(b) Address 804 N. Broadway

17 (a) Burial (b) Date thereof June 11, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Maryland

18 (a) Funeral director William Cook, Inc.,
(b) Address 1217 St. Paul Street

19 (Date rec'd by registrar) JUN 9 - 1947 (Signature of Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 1947, at 6:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1945 to June 1947, and that I last saw him alive on May 31 1947.

	Duration
Immediate cause of death Chronic myocarditis & myocardial degeneration	3
Due to Generalized Arteriosclerosis	3
Due to Senility	2
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lemuel Bull M. D.
Address 1221 N. Luzerne Ave. Date signed June 8, 1947

G52121 Boston

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓.13 B

Registered No. G52121

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 634 N. Gilmor St
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 634 N. Gilmor
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John W. H. Boston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1 - 1884

8. AGE: Years	Months	Days	If less than one day
53	1	6	hr. min.

1894

9. Birthplace Annapolis Md.
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name John Boston
13. Birthplace Md.

MOTHER
14. Maiden Name Rachel A. Coates
15. Birthplace Md.

16 (a) Informant Rachel Boston
(b) Address 634 N. Gilmor St.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 6-10-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Lot

18 (a) Funeral director Samuel W. Sullivan Jr.
(b) Address 1911 W. Arlington Ave

19 JUN 9 - 1947 (Date rec'd by registrar) (b) Hunter Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/7/47 19 , at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/2/47 19 to 6/7 19 47.
and that I last saw h alive on 6/7 19 47.

Immediate cause of death Pulmonary Tuberculosis — Duration 18 Mos.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. W. Reckling
Address 726 N. Howard Date signed 6/9/47

R. W. Reckling

VS 3

G52122

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 149a

Registered No. G52122

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 451 Walton Court (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Whitlock

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Craig Whitlock

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 3-2-1914

8. AGE: Years 33 | Months 32 | Days 3 | If less than one day ... hr. ... min. | 7

9. Birthplace Pittsburg Pa. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Lemuel Scott
13. Birthplace Pa.

MOTHER
14. Maiden Name Fannie Grisby
15. Birthplace Pa

16 (a) Informant Craig whitlock
(b) Address 451 Walton court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-12-47 (month) (day) (year)
(c) Cemetery or crematory Allegheny
Location Pittsburgh, Pa.

18 (a) Funeral director Charles L. Lowe
(b) Address 823 Washington Blvd, Williamsport, Md.

19 JUN 9 - 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-9- 1947, at 3:35 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-15-47 19 to 6-9- 1947, and that I last saw h.R alive on 6-9- 1947

Immediate cause of death	Duration
Carcinoma of Sigmoid Colon	12 hours
Due to Hemmorrhage	10 hours
Due to Peritonitis	1 day
Other Conditions	12 hours

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis E. Baum M. D.
Address 734 W Monument St. Date signed 6-9-47

VS 150

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

45a

Registered No. G52123

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st Sts.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 181 days
(e) Length of stay in Baltimore (yrs., mos., or days) 181 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Ohio (b) County
(c) City or town Cleveland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1014 St. Clair Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Philip Mc Mahon

3 (b) If veteran, name war —
3 (c) Social Security Account No. 365-18-1101

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 16, 1884

8. AGE: Years 63 | Months 3 | Days 18 | If less than one day hr. min.

9. Birthplace Troy, NY
(Town, county, and state)
10. Usual Occupation Fireman & oiler -MS
11. Industry or business Seafarer

FATHER
12. Name Philip Mc Mahon
13. Birthplace Boston, Mass.

MOTHER
14. Maiden Name Henrietta Boicott
15. Birthplace Troy, NY

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-10-47 (month) (day) (year)
(c) Cemetery or crematory
Location
18 (a) Funeral director
(b) Address 403-6-25th St
19 JUN 9 1947 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5 1947, at 9:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 4 1946, to June 5 1947, and that I last saw h. alive on June 5 1947.

Immediate cause of death	Duration
Carcinoma, squamous cell (primary lower lip resected)	more than 2 years
Due to metastasis to left neck, left face and left of mandible	
Due to Pneumonia, lobular- left lung	10 days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Lewis McL. Wilson M. D.
Address U.S. Marine Hosp. Date signed 6/7/47

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

109 B

Registered No. G52124

5241

Died, on June 8, 1947, Genevieve Seigel, beloved wife of the late Henry Seigel and devoted sister of Mrs. Daisy S. Tyre, Mrs. Earl Riegler and George Sauers.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 313 E. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs. Genevieve Seigel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Henry Seigel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/12/87

8. AGE: Years	Months	Days	If less than one day
59	10	27	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Paul Sauers
13. Birthplace Balto

MOTHER
14. Maiden Name Genevieve Pfeffer
15. Birthplace Balto

16 (a) Informant Mrs. Daisy S. Tyre
(b) Address 1312 North Ave

17 (a) Burial (b) Date thereof 6/11/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew Cemetery
Location Belair Rd

18 (a) Funeral director J. Abrams & Co.
(b) Address 2132 Eastern Ave

19 JUN 9 - 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/8/1947 at 5-00 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 6/5/1947 to 6/8/1947 and that I last saw her alive on 6/8/1947

Immediate cause of death Resp. Failure

Due to Pneumonitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard W. Sills M.D.
Address Mercy Hosp Date signed 6/8/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

No. G52125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

Registered No. G52125

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4506 Parento Ave
(c) Hospital or institution: Colonial Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 59 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2537 Loyola Southway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ellis Schaeffer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Ray

6 (c) If give, give age years

7. Birth date of deceased (mo., day, yr.) 6-22-1887

8. AGE: Years	Months	Days	If less than one day
59 60	11	16	hr. min.

9. Birthplace England (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Henry ?. England

13. Birthplace

MOTHER 14. Maiden Name Jennie England

15. Birthplace

16 (a) Informant Dr Aaron Schaeffer

(b) Address 2537 Loyola Southway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-10-47 (month) (day) (year)

(c) Cemetery or crematory

Location Hebrew Friendship Cem

18 (a) Funeral director Jack Lewis Inc

(b) Address 1429 E Balto St

19 (a) (Date rec'd by) JUN 9 - 1947 (b) Washington Hollins Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-8-47 19 , at 11A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/20/19 47 to 6/8/19 47 and that I last saw h alive on 6/6/19 47.

Immediate cause of death	Duration
Congestive Heart Failure	1 wk
Due to Carcinoma Lung - Neck & Thorax	1 yr.
Due to Malnutrition	3 mo.
Other Conditions Pre Frontal Lobectomy. (Include pregnancy within 3 months of death)	

Date of operation Pre Frontal Lobectomy

Major findings of operation:

Therapeutic — To relieve Pain.

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas Martin Jr

Address 933 N. Balto St Date signed 6/9/47

C52426 Job approved by Medical Examiner 94a

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C52426

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1931 W. North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1931 W. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: HARRY M. DYSON, Sr.

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No. 213-09-6918

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Alice M. Dyson
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 13, 1891
8. AGE: Years 55 | Months 6 | Days 24 | If less than one day hr. min.
9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Shipping Clerk
11. Industry or business Md. Biscuit Co.

FATHER
12. Name Wm. T. Dyson
13. Birthplace A. A. Co., Md.

MOTHER
14. Maiden Name Luvenia Chaney
15. Birthplace A. A. Co.

16 (a) Informant Mrs. Alice M. Dyson
(b) Address 1931 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/11/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore National Cem
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md. Hamilton or Belair, Md.

19 (a) JUN 9 - 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7 1947, at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 7 1947 to June 7 1947, and that I last saw h[illegible] alive on June 6 1947.

	Duration
Immediate cause of death: Coronary Thrombosis	15 Minutes
Due to: Coronary Sclerosis	6 Months
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
Signature Harry Coleman M.D.
Address 1924 W North Ave Date signed June 8 1947

V S 190 Chester J. Kubinski M.D. / per Earl L Royer M.D. X

G52127

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V131a

Registered No. G52127

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MARYLAND GENERAL HOSPITAL V
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2606 Talbott Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME KATHERINE PLUNKETT

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
W F	W	Single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 14, 1877

8. AGE: Years	Months	Days	If less than one day
69	6	23	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Part-Time Agent
11. Industry or business Equitable Life Assurance Co

FATHER
12. Name Michael H. Plunkett
13. Birthplace Ireland

MOTHER
14. Maiden Name Sarah Charlotte Waters
15. Birthplace Gaithersburg, Md.

16 (a) Informant Mrs. Florence P. Stewart
(b) Address 4429 Clifton Rd. 16

17 (a) Burial (b) Date thereof 6/10/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto. Md.

18 (a) Funeral director Wm. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md.

(Signature of undertaker) Hamilton for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/7 1947, at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/4 1947 to 6/7 1947 and that I last saw HER alive on 6/6 1947.

Immediate cause of death UREMIA — Duration 3 DAYS

Due to HYPERTENSIVE CARDIO-VASCULAR RENAL DISEASE

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles W. Stewart, Jr. M. D.
Address MD. GEN. HOSP. Date signed 6/7/47

VS 150

G52428

BALTIMORE CITY HEALTH DEPARTMENT

BCH B80214 / 161a

CERTIFICATE OF DEATH

Registered No. G52428

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1022 Linden Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1022 Linden Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Shirley Ann Terry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3

8. AGE: Years	Months	Days	If less than one day
			hr. 30 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Hubert Terry
13. Birthplace

MOTHER
14. Maiden Name Maggie Chambers
15. Birthplace

16 (a) Informant Mrs. Hubert Terry
(b) Address 1022 Linden Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School JUN 9 1947

18 (a) Funeral director Commissioner of Health
(b) Address

JUN 9 1947 Harry Williams M.D.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1947, at 4:30 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Jun death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Atelectasis, pneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Homer D. Mueller M.D.
Medical Examiner.
Date signed 6-6-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52429

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G52429 Registered No. 164c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Charles Town (W.J.M.) (If outside city or town limits, write RURAL and give town)
(d) Street No. 300 E. Washington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Raymond Edwards

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Louise E. Edwards
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 15, 1904

8. AGE: Years	Months	Days	If less than one day
43	3	22	hr. min.

9. Birthplace Charles Town W. Va. (Town, county, and state)
10. Usual Occupation Plumber
11. Industry or business

FATHER
12. Name Frank Edwards
13. Birthplace Jefferson Co., W. Va.

MOTHER
14. Maiden Name Edith Rowland
15. Birthplace Jefferson Co., W. Va.

16 (a) Informant Melvin G. Strider F. D.
(b) Address Charlestown W. V.

17 (a) ~~Burial~~ REMOVAL (Burial, cremation, or removal) (b) Date thereof 6/10/47 (month) (day) (year)
(c) Cemetery or crematory Edgehill Cem.
Location Charles Town, W. Va.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 1947 (Filed by registrar) (b) Thurlington Williams, M.D. Registrar

vs 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7, 19..., at 2:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet Wound of brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-3-47 at ? M.
(b) Where did injury occur? 300 E. Washington St Charles Town W. Va.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Gunshot - Self inflicted

23. Signature [signature] M.D. Medical Examiner.
Date signed 6-7-47

G52430

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G52430

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Carolina St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ MOS
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 N. Carolina St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sister Mary Carmel O.S.F.

3 (b) If veteran, name war

3 (c) ~~Social~~ Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 12-1869

8. AGE: Years 77 | Months 9 | Days 27 | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Sister of O.S.F.

11. Industry or business

FATHER 12. Name John Walsh
13. Birthplace Ireland

MOTHER 14. Maiden Name Anna Kelly
15. Birthplace Ireland

16 (a) Informant Sister M. Pierre
(b) Address St Joseph Hosp

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-20-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Leonard J Rysh
(b) Address 5305 Harford Rd

19 (a) 1947 (by registrar) (b) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/18/47 19..., at 11:19 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/13 1947 to 6/18 1947 and that I last saw h.r. alive on 6/18 1947

Immediate cause of death: Cardiorespiratory Failure — Duration: Days

Due to: Intestinal Obstruction

Due to: Arteriosclerosis - Generalized

Other Conditions: Coronary Arteriosclerosis, Pernicious Anemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard R. Young, M.D.
Address St Joseph Hosp Date signed 6/18/47

1224

BALTIMORE CITY HEALTH DEPARTMENT

G52131 109436 CERTIFICATE OF DEATH 186a G52131

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2- 11
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1235 E. Eager St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lena Shaughnessy

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3rd/1870

8. AGE: Years	Months	Days	If less than one day
76	7	3 4	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Anton
13. Birthplace Germany

MOTHER
14. Maiden Name Mary
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 10/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore
18 (a) Funeral director Rita Wiedefeld
(b) Address 900 East Biddle St.
19 (a) (Signature) by registrar (b) Huntington Williams M.D. Registrar

9- 1947
VS 150

MEDICAL CERTIFICATION A.M

20. DATE OF DEATH June 7th 1947, at 6.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 26th 1947 to June 7th 1947, and that I last saw her alive on June 7th 1947.

Immediate cause of death	Duration
Cerebrovascular accident (new)	10 days
Due to Hypertensive cardiovascular disease.	
Other Conditions: 1. Fracture, neck, right humerus 2. Fracture neck, right femur. 3. Cerebrovascular accident (old) with hemiplegia.	

(Include pregnancy within 3 months of death)

Date of operation 4/9/47
Major findings of operation: Fracture neck right femur.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 10/2
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 3/12/47 at 2 M
(c) Where did injury occur? Baltimore, Md. 1235 E. Eager (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home While at work? no (Specify type of place)
(e) Means of injury: Slipped & fell on steps.
23. Signature H B Gibbs M.D.
Address Balti. City Hospitals Date signed 6/7/47

For Medical Examiner's Approval Wm. A. Helfrich MD / per L. A. Merrill M.D.

G52132

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1248

G52132 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 141 S. Calverton Road
(c) Hospital or institution: 20-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 141 S. Calverton Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Adolph William Streiman

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. 214-01-5091

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Ada L. Streiman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 8, 1893

8. AGE: Years	Months	Days	If less than one day
53	9	1	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Automobile Mechanic
11. Industry or business American Ice Co.

FATHER
12. Name Martin Streiman
13. Birthplace Lithuania

MOTHER
14. Maiden Name Josephine Buchmeier
15. Birthplace Germany

16 (a) Informant Ada Caroline Streiman
(b) Address 141 S Calverton Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-11-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Maryland

18 (a) Funeral director George L. Sherwal
(b) Address 2101 Frederick Ave.

19 (a) (Filed by registrar) (b) Registrar

JUN 9 1947
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9, 1947, at 12:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1947 to June 9 1947 and that I last saw him alive on June 8 1947.

Immediate cause of death: Cirrhosis Of Liver — Duration: 2 yrs.
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas Reiter M.D.
Address 2145 W Balto St Date signed 6-9-47

X

G52133

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

√467

G52133 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 week

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Dorchester
(c) City or town East New Market
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank H. Harrison

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Edith B. Harrison

6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) May 11, 1888

8. AGE: Years 59 | Months - | Days 28 | If less than one day ____ hr. ____ min.

9. Birthplace Chester, Penna. (Town, county, and state)

10. Usual Occupation Restaurant Prop.

11. Industry or business

FATHER 12. Name Frank H. Harrison

13. Birthplace Canada

MOTHER 14. Maiden Name Mary Eliza Clark

15. Birthplace Barkington, England

16 (a) Informant Mrs Edith B. Harrison

(b) Address East New Market Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/13/47 (month) (day) (year)

(c) Cemetery or crematory Cemetery

Location Chester, Penna.

18 (a) Funeral director H. B. McDougalty

(b) Address Hurlock Md

19 (a) 1947 (Date received by registrar) (b) Registrar

Huntingtown, Williams, Md

Balto. Md.

X

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-8- 1947, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-1 1947, to 6-8 1947, and that I last saw him alive on 6-8 1947.

Immediate cause of death	Duration
respiratory failure	
due aspiration of vomitus	
due resection due paralytic ileus	
Due to mesenteric thrombosis	
Due to carcinoma of rectum	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 6-3-47

Major findings of operation: Carcinoma of rectum

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John B Hurley, M. D.

Address Univ. Hosp. Date signed 6-9-47

G52434

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G52434 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 223 N. Linwood Avenue
(c) Hospital or institution: Home 6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 223 N. Linwood Avenue (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore, Md. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elmer C. Whittemore

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	212 01 2283

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Julia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 11 1882

8. AGE: Years	Months	Days	If less than one day
64	5	27	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Bookkeeper
11. Industry or business

FATHER
12. Name John R. Whittemore
13. Birthplace Baltimore

MOTHER
14. Maiden Name Fannie Perry
15. Birthplace Baltimore

16 (a) Informant Mrs. Lilthon Stnehler
(b) Address 223 N. Linwood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 11 (month) (day) (year)
(c) Cemetery or crematory Cemetary
Location Baltimore

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 JUN 10 1947 (Date rec'd by registrar) Huntington Hillmeyer, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 1947, at 8.05 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 3 1947 to June 8 1947 and that I last saw him alive on June 8 1947

Immediate cause of death: Myocardial failure
Due to: Diabetes Mellitus
Due to: Bronchopneumonia Lobularis
Due to: Senile Atrophy

Duration: 2 days / 1 day

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. H. Clarke M. D.
Address 1623 E. Monument Date signed 6/9/47

G52135

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 192B

G52135 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St.
(c) Hospital or institution:
Home for the Aged Blind
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. Valley & Eager Sts
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Brewster (LILLIAN R BREWSTER)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced. S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4 1872

8. AGE: Years 74 | Months 11 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Seamstress

11. Industry or business

FATHER
12. Name John Brewster
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Cath. Akers
15. Birthplace Balto Md.

16 (a) Informant Luther Donaldson
(b) Address 2411 Eutaw Pl

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/12/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

19 JUN 10 1947 (Date received by Local Registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 1947, at 1.2 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1947 to June 9 1947 and that I last saw her alive on June 8 1947.

Immediate cause of death	Duration
Edema Lungs	1 Day
Due to Mitral Stenosis	5 Yrs
Due to	
Other Conditions Arterio Sclerosis	10 Yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Gill Hall
Address 1631 E North Av Date signed 6/9/47 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

52136

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √47

G52136 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use black ink. Do not abbreviate. Where exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 941 Gorsuch Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 941 Gorsuch Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME GEORGE S. HARRISON

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 212-01-1232

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Alma M
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4, 1881

8. AGE: Years 66 | Months 0 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Printer
11. Industry or business

FATHER
12. Name George Harrison
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Alma Harrison
(b) Address 941 Gorsuch Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/11/47 (month) (day) (year)
(c) Cemetery or crematory Prasbytarian, Govans
Location Baltimore, Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 6 10 1947 (Date received by registrar) (Signature of registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8, 1947 19..., at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 15 1946, to June 8 1947, and that I last saw h... alive on June 5 1947.

Immediate cause of death: Carcinoma Right Lung — Duration: 18 months
Due to:
Due to:
Other Conditions: —
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: None
(b) Date of occurrence: — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury: None

23. Signature: L. L. Grady M.D.
Address 5106 Harford Rd Date signed 6/9/47

G52137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G52137 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital 11-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 40 W. Biddle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Annie Fookes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Late Louis Fookes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 29, 1884

8. AGE: Years	Months	Days	If less than one day
62 6y	7	11	hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

MOTHER / FATHER

12. Name Kiev Handelman

13. Birthplace Russia

14. Maiden Name Mary Angelowitz

15. Birthplace Russia

16 (a) Informant Annie Fookes

(b) Address 40 W. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 10/47 (Month) (day) (year)

(c) Cemetery or crematory Bnai Israel Cemetery

Location Southern ave

18 (a) Funeral director Sol Furman & Bro.

(b) Address 1124-26 W North ave

(c) Date received JUN 10 1947 Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 1947, at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/4 1947 to 6/9 1947 and that I last saw him alive on 6/9 1947

Immediate cause of death	Duration
Cardiac collapse.	
Due to Coronary occlusion	
Due to Jaundice Thrombosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature August Kiel

Address Mercy Hosp. Date signed 6/9/47
M. D.

X

G52138

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

Registered No. G52138

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1201 Myrtle Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sumberland W. Sterling

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 220-09-0257

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/3/1921

8. AGE: Years 25 | Months 6 | Days 5 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name Walter Sterling
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Elsie Richardson
15. Birthplace Baltimore Md.

16 (a) Informant Elsie Sterling
(b) Address 736 George St.

17 (a) ____ (Burial, cremation, or removal) (b) Date thereof June 12 1947 (month) (day) (year)

(c) Cemetery or crematory Auburtus.
Location Auburtus Md.

18 (a) Funeral director Leonard Wheeler
(b) Address 1041 Myrtle Ave

19 JUN 10 1947 Registrar by Washington Williams

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8, 1947, at 6.30 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Hemorrhage from incised wounds of neck.

Due to: Stab-wounds of left chest and left lung.

Other Conditions:
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-8-47 at about 6 a. M.
(b) Where did injury occur? Outside- 1324 Pennsylvania Ave. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Sharp instrument

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 6-9-47

G52139

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G52139

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St Joseph's Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 706 Cedarcroft Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary L. Baker (Mary Isabella Baker)

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: F. | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: ## Charles L. Baker
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) 2/27/84

8. AGE: Years 63 | Months 3 | Days 12 | If less than one day ##### min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Michael Dauenhauer
13. Birthplace: Tennessee

MOTHER
14. Maiden Name: Anna Smith
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mr. Charles L. Baker
(b) Address: 706 Cedarcroft Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/11/47 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Rd. Balto: Md.

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

JUN 10 1947 (Date rec'd by Registrar) (b) [illegible] Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/8/47 19 at 5105 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 6/8/47, and that I last saw h.e.r. alive on 6/8/47 19

Immediate cause of death: Coronary occlusion — Duration
Due to: Cerebral Thrombosis
Due to: Mural Thrombus
Other Conditions: Pericarditis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address St. Joseph's Hosp. Date signed 6/9/47

X

G52110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G52110 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3910 Woodbridge Rd
(c) Hospital or institution: —
16
(d) Length of stay in hospital or inst. (yrs., mos., or days) ~~4~~
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3910 Woodbridge Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter H. Davis

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-1905

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: ~~Sarah~~ Davis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 3 1876

8. AGE: Years 70 | Months 8 | Days 7 | If less than one day hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation Painter

11. Industry or business Balto. House a.

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Edgar Martindale
(b) Address 3910 Woodbridge Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-9-47 (month) (day) (year)

(c) Cemetery or crematory Londow Park
Location Balto. Md

18 (a) Funeral director Geo. L. Bayer Jr
(b) Address 1512 Hollins St

JUN 10 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6, 1947, at 8:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1947 to June 6 1947, and that I last saw him alive on June 5 1947.

Immediate cause of death: uremia — Duration 6 Months

Due to chronic nephritis with hypertension — Duration unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nathan Rosen

Address 206 S. Gilmor St Date signed 6-6-47

VS 150

G52141

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G52141

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 24
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3512 Virginia Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lena Goldberg

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Joseph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-10-1885

8. AGE: Years	Months	Days	If less than one day
61	6	29	hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Howard Goldberg
(b) Address 3815 Beehler Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-10-47 (month) (day) (year)
(c) Cemetery or crematory Loudale
Location Philadelphia Rd + Hamilton Ave
18 (a) Funeral director Jack Lewis Inc
(b) Address 429 E Balto St

(Date received) (Registrar)

JUN 10 1947 Huntington Williams M.D.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 1947 at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 9 1947 to June 1947. and that I last saw alive on June 9 1947.

Immediate cause of death Cardiac Failure

Due to Arteriosclerotic & Hypertensive Cardiovascular Disease

Due to Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jerry Cohen M. D.
Address Sinai Hosp Date signed 6/9/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RANGIN RESERVED FOR BINDING

Body removed to Hospital by Medical Examiner (E Dubois, M D)
Viewed by Dr Cameron

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65,419

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1316 Edmondson ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Trevit (TRUITT)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Black

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3 6 1895

8. AGE: Years 52 | Months 3 | Days 2 | If less than one day hr. min.

9. Birthplace Hanover Penn Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William Smith

13. Birthplace

MOTHER 14. Maiden Name Ella Johnson

15. Birthplace

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 12 47 (month) (day) (year)

(c) Cemetery or crematory Chase Cem

Location Chase Md

18 (a) Funeral director Adolphus Hailstead

(b) Address 918 Druid Hill Ave.

(c) Washington Williams M.D. (Signature of registrar)

JUN 10 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-8-47, at 8:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-8-47 to 6-8-47.
and that I last saw her alive on 6-8-47

Immediate cause of death Cerebral embolism — Duration Extr

accident

Due to Hypertension & arteriosclerosis

Due to

Other Conditions Syphilis treated

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward J Dubois M. D.

Address Johns Hopkins Hospital Date signed 6-9-47

C52143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C52143

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. T... correct age is especially important. Physicians: please write... write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver Sts.
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. Route 16 Box 163 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Martha L.E. Riess

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: George Riess

6 (c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.) 9/1/91

8. AGE: Years 55 | Months 9 | Days 9 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Hope

11. Industry or business

FATHER — 12. Name Frederick Puepke

13. Birthplace Germany

MOTHER — 14. Maiden Name Lydia

15. Birthplace Germany

16 (a) Informant Mr. George Riess

(b) Address Back River Road

17 (a) burial (Burial, cremation, or removal) (b) Date thereof June 13/47 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location 3801 Frederick Ave.

18 (a) Funeral director Lanahan Funeral Home

(b) Address 7401 Belair Road

(c) JUN 10 1947 (Date received by registrar) (d) Thurlington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 1947 at 9:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19..., and that I last saw her alive on 6/9/1947

Immediate cause of death — Cardio respiratory failure — Duration

Due to Pulmonary Edema

Due to Chronic Passive Congestion

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry T. Williams Jr. M.D.

Address St. Josephs Hosp. Date signed 6/9/47

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G52144

G52144

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4515 Garrison Blvd.
(c) Hospital or institution: Ventura Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1529 N. Washington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY C. FOSTER

3 (b) If veteran, name war: --
3 (c) Social Security Account No.: --

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widow
6 (b) Name of husband or wife: David E. Foster
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.)
8. AGE: Years: about 87 Months: Days: If less than one day: hr. min.
9. Birthplace: Baltimore (Town, county, and state)
10. Usual Occupation: -
11. Industry or business: -

FATHER
12. Name: Timothy Jones
13. Birthplace: Baltimore

MOTHER
14. Maiden Name: -
15. Birthplace: Baltimore

16 (a) Informant: Mr. Allan Cleaveland
(b) Address: 2124 Mt. Holly St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/11/47 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 JUN 10 1947 (Date received by Registrar) [illegible]

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1 1946, to 6-9 1947, and that I last saw h[illegible] alive on 6-9 1947

Immediate cause of death	Duration
Hypostatic Pneumonia	3 days
Due to Chronic Myocardial Degeneration	1 year
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howard W. Leverton M. D.
Address 2084 Garrison Blvd Date signed 6-9-47

G52445

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G52445 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 744 E. Preston St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME PAUL J FEEHAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 23-1895

8. AGE: Years	Months	Days	If less than one day
51	2	14	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name JOHN T. FEEHAN

13. Birthplace BALTIMORE

MOTHER 14. Maiden Name CAROLYN WILCOX

15. Birthplace BALTIMORE

16 (a) Informant Elva Gore

(b) Address 1905 Cedric Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof JUNE 11-47 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Frederick Road

18 (a) Funeral director Chas. F. Evans & Son

(b) Address 118 W. Mt. Royal Ave

19 JUN 10 1947 Huntington Williams MD

(Date received by local registrar) (Signature of local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/8/47 19.., at 5 00 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/7 1947, to 6/8 1947, and that I last saw him alive on 6/8 1947.

Immediate cause of death	Duration
Resp. failure	
Due to Hypertension & C.V.D.	5 day
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature August Keel M. D.

Address Mercy Hospital Date signed 6/9/47

G52146

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √167

G52146 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 13
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2618 Woodbrook ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Earl Walker

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/6/1929

8. AGE: Years 18 | Months - | Days 1 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name Prime Walker
13. Birthplace Md

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Raymond Stafford
(b) Address 2618 Woodbrook Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/11/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Pennsylvania Ave

JUN 10 1947 (b) Huntington Williams M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7, 1947 at 8 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hemorrhage
due to stab wound
of abdominal aorta

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6/7/47 at 7:20 P. M.
(b) Where did injury occur Stockton & Cumberland
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Sharp Instrument

23. Signature Carl L. Key M.D. (Medical Examiner.)
Date signed 6-7-47

C52147

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

Registered No. C52147

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dutheland & Raynor
(c) Hospital or institution: West Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 27

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore - 15 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3314 Woodland Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Abbott

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or
MALE	WHITE	Married

6 (b) Name of husband or wife Edna M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 19 1890

8. AGE: Years	Months	Days	If less than one day
56	8	18	hr. min.

9. Birthplace Baltimore, Maryland (Town, county and state)
10. Usual Occupation Plumber
11. Industry or business

FATHER
12. Name James Edward Abbott
13. Birthplace Liverpool, Va

MOTHER
14. Maiden Name Catherine Glaser
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs Edna M Abbott
(b) Address 3032 W Saratoga Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-10-47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Maryland

18 (a) Funeral director Sorrig Bros
(b) Address 5005 Park Heights Ave

19 JUN 10 1947 Walter Williams MD (Date rec'd by registrar) (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7 1947, at 2:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19__, to 19__, and that I last saw h.i.m alive on 19__.

Immediate cause of death Acute cardio vascular circulatory collapse — Duration

Due to Died on arrival

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature Earl L. Chambers M. D.
Address 4408 Liberty Hts Date signed 6/10/47

John P. Davis MD / per G. G. Merrill MD

G52148

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G52148

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 1-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5-17 S. Bradford Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John F. Carrigan (Carrigan)

3 (b) If veteran, name war: World War II

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17, 1911

8. AGE: Years	Months	Days	If less than one day
36	-	24	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John P. Carrigan
13. Birthplace Baltimore City, Md.

MOTHER
14. Maiden Name Eva M. Lukasiewska
15. Birthplace Pittsburgh, Pa.

16 (a) Informant James A. Carrigan
(b) Address 411 S. Ann St.

17 (a) Burial (b) Date thereof 6/12/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location German Hill Road

18 (a) Funeral director M. W. E. Pippel's Sons
(b) Address Lombard & Fan Sts.

19 JUN 10 1947 Huntington Williams, M.D.
(Local registrar's signature) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10, 1947, at 12 40 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carlton Ryder M.D.
Medical Examiner.
Date signed 6/10/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52149

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1136

G52149 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2309 Washington Blvd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 3
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2309 Washington Blvd (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank B. Drocella

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mary E. Heath

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec 23rd 1901

8. AGE: Years 45 | Months 5 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation machinist

11. Industry or business Ice Co.

FATHER
12. Name Frank Drocella
13. Birthplace Germany

MOTHER
14. Maiden Name Rose Heath
15. Birthplace Germany

16 (a) Informant Mrs. Mary E. Drocella
(b) Address 2309 Washington Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/12/47 (month) (day) (year)
(c) Cemetery or crematory London Park Cem
Location 3801 Hyderick Rd.

18 (a) Funeral director John J. Gowan & Son
(b) Address 901-03 Huntington Ave, Baltimore, Md.

19 (a) Date received JUN 10 1947 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9th 1947, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1947 to June 9 1947 and that I last saw him alive on June 8 1947.

	Duration
Principle cause of death: Miliary tuberculosis	
Due to: Pulmonary T.B.	
Due to: Left Pulm. Collapse	
Other Conditions: Mitral Stenosis	
Hypertension	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. E. Spitznagle M.D.
Address Lansdowne, Md. Date signed 6/9/47 D.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

G52150 CERTIFICATE OF DEATH ✓ 93D Registered No. G52150

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eastern & Wilkens Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Hanover Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry W. Dunkerly

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Catherine C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20 1878

8. AGE: Years	Months	Days	If less than one day
68.	10	19	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Machinest

11. Industry or business B & O R.R.

FATHER
12. Name John K. Dunkerly
13. Birthplace Maryland

MOTHER
14. Maiden Name Lafra
15. Birthplace Maryland

16 (a) Informant Mrs Catherine C. Dunkerly
(b) Address Hanover Md.

17 (a) Burial (b) Date thereof 6/11/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St Augustines Cem.
Location Elkridge Md.

18 (a) Funeral director John J. Cavanaugh Sons
(b) Address 927-33 W. Lombard St

19 (a) JUN 10 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 June 1947, at 7.30 P.M. ✓

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Pulmonary Edema, Acute

Due to Arteriosclerotic Cardio-Vascular Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer, Jr. M.D.
Medical Examiner.
Date signed 9 June 1947

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G52151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1213

Registered No. G52151

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. Gen. Hosp. 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dod
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2610 Pierpont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years	Months	Days	If less than one day
73			hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Raisin L Williams
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Amelia Addison
15. Birthplace Balto. Md.

16 (a) Informant Amelia Wesley
(b) Address 2610 Pierpont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-10-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St.

19 (a) JUN 10 1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 1947, at 5:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D. (Medical Examiner)
Date signed 6-9-47

VS 181

G52152 BCH 980555 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 161c Registered No. G52152

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2024 W. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George H. Burley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. ~

6 (b) Name of husband or wife ~

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5, 1947.

8. AGE: Years | Months | Days 4 3 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation ~

11. Industry or business

FATHER 12. Name James Burley.
13. Birthplace A. A. County, Md.

MOTHER 14. Maiden Name Sarah Hall.
15. Birthplace Bethlehem, Pa.

16 (a) Informant James Burley.
(b) Address 2024 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-12-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion,
Location

18 (a) Funeral director Mc Katie R. Williams
(b) Address 2221 N. Schroeder St.

19 JUN 10 1947 Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 1947, at 3.45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Status Thymicolymphaticus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Penn M.D.
Medical Examiner.
Date signed 6-9-47

VS 151

G52153

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G52153 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County St. Mary's
(c) City or town Ridge (If outside city or town limits, write RURAL and give town)
(d) Street No. St. Michael's Rectory (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rev. Walter De Sowalder, S.J.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/28/10

8. AGE: Years	Months	Days	If less than one day
37	4 3	9	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Priest
11. Industry or business

FATHER 12. Name Jacob De Sowalder
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Annie Henderson
15. Birthplace Baltimore, Md.

16 (a) Informant Rev. Baltazar
(b) Address St. Michael's Rectory

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/12/47 (month) (day) (year)
(c) Cemetery or crematory Woodstock College Cem.
Location Woodstock, Maryland

18 (a) Funeral director H. K. Mears & Son
(b) Address 805 N. Calvert St.

19 (a) Date received (month) (day) (year) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION 45

20. DATE OF DEATH June 9 1947, at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/19 1947 to 6/9 1947 and that I last saw him alive on 6/9 1947

Immediate cause of death Resp. failure
Due to Uremia
Due to Glomerulo nephritis, chronic
Other Conditions H.C.U.D.
(Include pregnancy within 3 months of death)
Date of operation 6/5/47
Major findings of operation Cut stone in bladder
of autopsy

Duration

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature August Kiel M. D.
Address Mercy Hosp. Date signed 6/9/47

VS 150

G52154 BC# B 81720 119a

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G52154

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 17-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 574 Oxford St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Floyd Montgomery

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30th 1947

8. AGE: Years	Months	Days	If less than one day
		8	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name George Montgomery
13. Birthplace Germany, South Carolina

MOTHER
14. Maiden Name Emma Brown
15. Birthplace Tuskegee, Ala.

16 (a) Informant George Montgomery
(b) Address 574 Oxford St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 10, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Brooklyn Md.

18 (a) Funeral director Chas O. Wilson
(b) Address 1000 Brantley ave

19 (a) JUN 10 1947 Baltimore, Md. (Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7 1947, at 9:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1947 to June 7 1947, and that I last saw him alive on June 7 1947.

Immediate cause of death	Duration
Diarrhea	
Due to Septicemia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward C. Smith M. D.
Address 1514 Division St. Date signed 6-9-47

VS 150

G52155

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1131a

Registered No. G52155

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNPADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 Nicoll ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 - 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 600 Nicoll (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country /

3 (a) **FULL NAME** Anna Grace Fisher

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7 / 5 / 1858

8. AGE: Years	Months	Days	If less than one day
88	11	3	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER 12. Name Marquesp J. Fisher
13. Birthplace Maryland

MOTHER 14. Maiden Name Eliz Mooney
15. Birthplace Maryland

16 (a) Informant Mrs. S. Buschman
(b) Address 600 Nicoll Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/11/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Moriah Cemetery
Location Homeland Park

18 (a) Funeral director Wm. J. Tracey & Son
(b) Address 1 E. Lexington St.

19 JUN 10 1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 8 1947, at 1130 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 3 1937 to Jan 8 1947
and that I last saw h/ alive on Jan 8 1947

Immediate cause of death
Arteriosclerosis
Chronic Myocarditis
Due to Chronic Interstitial Nephritis
Due to Interstitial
Other Conditions Acute Cardiac Dilatation

Duration
1940
1941
1942
1947

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? No While at work? (Specify type of place)
(e) Means of injury

23. Signature H. H. Bishop M. D.
Address 503 Shenandoah Ave. Date signed Jan 9, 1947

VS 150

G52156

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 57

Registered No. G52156

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Light St
(c) Hospital or institution: Sa. O.G.H. 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3510 Erdman Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER J. STASKOWIAK

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-03-6412

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife M

6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) 2-14-13

8. AGE: Years	Months	Days	If less than one day
34	3	24	hr. min.

9. Birthplace BALTIMORE MARYLAND (Town, county, and state)

10. Usual Occupation MACHINIST

11. Industry or business WESTERN ELECTRIC

FATHER 12. Name JOSEPH STASKOWIAK

13. Birthplace POLAND

MOTHER 14. Maiden Name STANISLAWA NOWACKA

15. Birthplace BALTIMORE, MARYLAND

16 (a) Informant MRS. MARY STASKOWIAK

(b) Address 3510 ERDMAN AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 6/11/47 (month) (day) (year)

(c) Cemetery or crematory ST STANISLAUS

Location MT. CARMEL ROAD

18 (a) Funeral director M. F. Sadowski Home

(b) Address 1848 Eastern Ave

19 (d) JUN 10 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

10

20. DATE OF DEATH 6-8 1947 at 7 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-7 1947 to 6-8 1947 and that I last saw h[illegible] alive on 6-8 1947

Immediate cause of death Resp. failure — Duration

Due to Brain tumor — 1 week

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M.D.

Address 1211 Light St Date signed 6-8-47

R S. Swindell X

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C52157

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. C52157

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 729 Stirling St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10-2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 729 Sterling St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Isabella Satterfield

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex Femal | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 24-1872

8. AGE: Years 75 | Months 2 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name John Griffin
13. Birthplace ? md

MOTHER 14. Maiden Name Amelia ?
15. Birthplace ? Va

16 (a) Informant Mrs Lucy Green
(b) Address 729 Sterling St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 6-12-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location a. a. Co.

18 (a) Funeral director Rayner Saunders
(b) Address 1412 E. Preston St.

19 (a) JUN 10 1947 (Date rec'd by Registrar) Registrar for Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-8 1947, at 5-10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-5 1946 to 6-8 1947 and that I last saw h.e.r alive on 6-6 1947.

Immediate cause of death	Duration
hypertensive cardio-renal disease	7 yrs
Due to	
Due to	
Other Conditions rheumatoid arthritis (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rayner Browne M. D.
Address 1500 E. Madison St Date signed 6/14/47

Rayner Browne x

VS 150

G52158 Bl#B17155

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

G52158 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Rural – Essex Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. Lot 19, Route 3, Old Battle Grd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country –

3 (a) FULL NAME R. Alfred Peterson OR Petersen

3 (b) If veteran, name war –
3 (c) Social Security Account No. –

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	single

6 (b) Name of husband or wife –
6 (c) If alive, give age – years

7. Birth date of deceased (mo., day, yr.) 1 – 19 – 1945

8. AGE: Years	Months	Days	If less than one day
2	4	21	____ hr. ____ min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Arnold Petersen
13. Birthplace Illinois

MOTHER
14. Maiden Name Marie Wiegmann
15. Birthplace Balto

16 (a) Informant Marie W. Petersen
(b) Address 7418 Old Battle Grove Rd.

17 (a) Burial (b) Date thereof 6 – 12 – 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem
Location German Hill Rd.

18 (a) Funeral director Tilley & Zeiler Inc
(b) Address 403 S. Wolfe St.

JUN 10 1947 (Date rec'd by registrar) Huntington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/9/1947 at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Drowning
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6/9/47 at about 1:30 P.M.
(b) Where did injury occur? Essex Md – on Old Battle Rd
(c) Did injury occur at home, on farm, industrial place, in public place? Bear Creek While at work? No
(d) Means of injury Fell into Bear Creek

23. Signature C. P. Luberecka M.D.
Medical Examiner.
Date signed 6/10/47

VS 181

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G52159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp. 1-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 DAY
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2222 E Eat St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Henninger

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Widow

6 (b) Name of husband or wife Edward
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1 — 9 — 1865

8. AGE: Years	Months	Days	If less than one day hr.	min.
82	4	29		

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name ? Black
13. Birthplace Balto

MOTHER
14. Maiden Name ? ?
15. Birthplace Balto

16 (a) Informant Bessie Langenmeier
(b) Address 410 N. Belnord Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/10/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Old Cornwell Rd

18 (a) Funeral director Selby & Zeiler
(b) Address 4038 Wolfe St.

19 (Signature of registrar) JUN 10 1947 Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 1947, at 1 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 7 1947, to June 8 1947, and that I last saw her alive on June 8 1947

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to ASCVD.	
Due to	
Other Conditions Coronary + arteriosclerosis + Hypertension	

Diabetes Mellitus
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: June 8, 1947

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leon Rosenbaum Jr. M.D.
Address Sinai Hospital Balto Date signed 6/8/47

93

G52160

BALTIMORE CITY HEALTH DEPARTMENT

BCH # D 80713 CERTIFICATE OF DEATH 157c

Registered No. G52160

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette and Calhoun Streets
(c) Hospital or institution: Franklin Square Hospital 15/12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3528 Reisterstown Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Meskowitz
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7, 1947 (8:12 pm)

8. AGE: Years	Months	Days	If less than one day
			2 hr. 10 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Milton Sam Meskowitz
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Judity Brassman
15. Birthplace Baltimore, Md.

16 (a) Informant Mother
(b) Address 3528 Reisterstown Rd, 15

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School JUN 10 1947
18 (a) Funeral director Commissioner of Health
(b) Address
JUN 10 1947 Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/1 1947, to 6/7 1947 and that I last saw him alive on 6/7/47 1947

Immediate cause of death Congenital deformity (Anencephalic?)

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stanley B. Klyanowicz M. D.
Address Franklin Sq Hosp Date signed 6/8/47

VS 150

G52161 BM #79457

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

111013 159

Registered No. G52161

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Hour
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1819 E. Pratt ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mc Guire James

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	N.B.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-29-47

8. AGE: Years	Months	Days	If less than one day
0	?	1	hr. min.

9. Birthplace MD. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Francis Edward
13. Birthplace ?

MOTHER
14. Maiden Name Florence
15. Birthplace M ?

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern AVE.

17 (a) 3.00 PM (Burial, cremation, or removal) (b) Date thereof 6-3-47 (month) (day) (year)
(c) Burial or crematory Cremated
Location 4940 Eastern AVE. B. C. H.

18 (a) Funeral director
Address 4940 Eastern AVE

19 JUN 10 1947 (Date rec'd by registrar) Washington Millimans M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH may -29 1947, at 8.10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 29 - 47 to May 29 - 47, and that I last saw h im alive on May 29 1947.

Immediate cause of death	Duration
Prematurity	life
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wilson E. Hughes M. D.
Address Balto City Hosp Date signed June 6, 47

VS 150

Hospital Disposal

G52162

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56a

G52162 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2m
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Bel Air
(If outside city or town limits, write RURAL and give town)
(d) Street No.....
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3 (a) **FULL NAME** Anna Klingaman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Claude Klingaman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan - 12 - 1883

8. AGE: Years 64 | Months 5 | Days 29 | If less than one day .....hr. .....min.

9. Birthplace Delaware
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Thomas Ryan
13. Birthplace England

MOTHER 14. Maiden Name Mary Phillips
15. Birthplace Pennsylvania

16 (a) Informant Claude Klingaman
(b) Address Bel Air Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 13/47 (month) (day) (year)
(c) Cemetery or crematory Bel Air
Location Bel Air

18 (a) Funeral director Degan & Foster
(b) Address Bel Air Md

19 JUN 11 1947 (b) Filed by (Date received) Wellington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June - 10 - 1947, at 6 25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June - 9 1947, to June - 10 1947, and that I last saw her alive on June - 10 - 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Pulmonary Infarct	
Due to Arteriosclerosis	over
Due to Metastatic Carcinoma	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature Wellington Williams M.D.

Address Medical Arts Bldg. Date signed 6/10/47

G52163

BALTIMORE CITY HEALTH DEPARTMENT

TN. 105272

CERTIFICATE OF DEATH

G52163 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7- 21
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 609 Gilbert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Roselee Holt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October ? 1912

8. AGE: Years 34 | Months 8 | Days ? | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Clarence Holt
13. Birthplace Maryland

MOTHER
14. Maiden Name Mamie Thomas
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-11-47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Road

18 (a) Funeral director Wm. Ignatius R. Williams
(b) Address 322 N. Schroeder St.

19 JUN 11 1947 (Date received by Registrar) Washington Nilliams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6th 1947 19 , at 8.35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 15 1946 to June 6th 1947, and that I last saw h.er alive on June 6th 1947

Immediate cause of death: Pulmonary tuberculosis — Duration: 4 years

Due to

Due to

Other Conditions: Chronically infected Abdominal incision
(Include pregnancy within 3 months of death)

Date of operation Dec. 3, 1946

Major findings of operation: Abdominal Pregnancy

of autopsy: same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hewright M. D.

Address Date signed 6-9-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

MARGIN RESERVED FOR BINDING

G52164

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V186a

Registered No. G52164

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address South Baltimore Gen.
(c) Hospital or institution:
1213 Light St.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town 4016 Eighth St.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore Md.
(If rural give location)
(e) Citizen of foreign country? U.S.A. (Yes or No)
If yes, name country

3 (a) **FULL NAME** Andrew K. Johansen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Jenny Johansen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6 5 94

8. AGE: Years	Months	Days	If less than one day
53	0	5	hr. min.

9. Birthplace Norway (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Md Dry Dock

FATHER
12. Name Rasmeus Johansen
13. Birthplace Norway

MOTHER
14. Maiden Name ?
15. Birthplace Norway

16 (a) Informant Patient
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/12/47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Balto Co Md

18 (a) Funeral director Fullerton Colonial
(b) Address 1217 E Lond St

19. ~~JUN 11 1947~~ Fullerton Millington Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/10/47 19 at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 19 47 to June 10 19 47 and that I last saw he alive on June 10 19 47

Immediate cause of death Left-Fractured Clavicle + Acromion Skull Fracture — Duration 10 Days

Due to Injuries

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 25/4
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence May 31 1947 at 1 A M
(c) Where did injury occur? Balto Balto Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Means of injury Pt fell down Alley 5 Steps

23. Signature Ernest Fullerton Jr M. D.
Address South Balto. Gen Hosp Date signed 6-11-47

G52165 Dr Walter Kolar 102 E Fort Ave

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G52165

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1504 Battery Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1504 Battery Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Mary A. Kellam

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ William H. Kellam
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 23rd 1866

8. AGE: Years	Months	Days	If less than one day
81	3	16	hr. min.

9. Birthplace Marion Station Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name John Garber
13. Birthplace Md.

MOTHER
14. Maiden Name Leah J. Howard
15. Birthplace Md

16 (a) Informant Audrey Kimball
(b) Address 1504 Battery Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/13/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto
Location Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

JUN 11 1947 (Date rec'd by local registrar) (b) ~~Huntington Williams M.D.~~ (Signature of local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9th 1947, at 8 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 19 to June 9 1947 and that I last saw ~~him/her~~ alive on June 7 1947.

Immediate cause of death: Cardiac failure — Duration 1 day
Pulmonary Edema — 1 day
Due to Arteriosclerotic — 2 yrs
Cardio-Vascular disease
Due to Senility —
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter Kolar M. D.
Address 102 E Fort Ave Date signed 6/10/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52166

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193

Registered No. G52166

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1014 Greenmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Wallis

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 8, 1930

8. AGE: Years	Months	Days	If less than one day
16	9	1	hr. min.

9. Birthplace S. Lakemont Pa.
(Town, county, and state)
10. Usual Occupation School Boy
11. Industry or business

FATHER
12. Name George Wallis
13. Birthplace S. Lakemont Pa.

MOTHER
14. Maiden Name Helen Kingston
15. Birthplace S. Lakemont Pa.

16 (a) Informant Mrs. Blanch Smith
(b) Address 1014 Greenmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 14, 1947 (month) (day) (year)
(c) Cemetery or crematory Cresse Town Cem. Pa.
Location Cresstown Cemetery Pa.

18 (a) Funeral director Edgar W. Coffin
(b) Address 924 E. Pages St. Baltimore Md.

JUN 11 1947 (Date rec'd by Registrar) (b) Huntingdon Williamsport, Md.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/9 1947, at 3:00 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Electrocution 3rd degree burns of face, neck and legs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6/9/47 about 2:30 P.M.
(b) Where did injury occur? Plant 5th Bridge at Penn R.R.
(c) Did injury occur at home, on farm, industrial place, in public place? Rail Road depot While at work? No
(d) Means of injury Contacted 2300 volt high tension wire

23. Signature Carl J. Sabitch M.D.
Medical Examiner.
Date signed 6/10/47

G52167 G52167

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1214

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 34 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County 3
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 529 Cumberland St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel M. Brown

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Married

6 (b) Name of husband or wife W. Emerson Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-4-96

8. AGE: Years	Months	Days	If less than one day
51		6	hr. min.

9. Birthplace Wash. D. C.
(Town, county, and state)
10. Usual Occupation House wife
11. Industry or business Home Residence

FATHER
12. Name George Perry
13. Birthplace Washington D. C.

MOTHER
14. Maiden Name Sue Kenney
15. Birthplace Keswick Va.

16 (a) Informant W. Emerson Brown
(b) Address 529 Cumberland St.

17 (a) Burial (b) Date thereof June 14 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Baltimore, Md.

18 (a) Funeral director Jas. B. Stewart
(b) Address Salisbury, Md.

19 JUN 11 1947 (b) Lexington Hilliard
(Date rec'd by Reg.) (Signature of Reg.)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1947, at 7 35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 8 1947 to June 10 1947. and that I last saw her alive on June 10 1947.

Immediate cause of death	Duration
Congestive Heart Failure	1 day
Due to Hypertensive Cardio-Vascular Renal Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. C. Carter M. D.
Address 608 N. Milton Ave. Date signed

G52168 G52168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3207 Barclay St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town Washington D. C.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 346 Bryant St N. W.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Henrietta Huggins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Madison Huggins

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 22nd 1894

8. AGE: Years 53 | Months 2 | Days 15 | If less than one day ..... hr. ..... min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Jerry Morton
13. Birthplace Va.

MOTHER
14. Maiden Name Nannie White
15. Birthplace Va.

16 (a) Informant Louise Morton
(b) Address 3207 Barclay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 11th 1947 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Virginia

18 (a) Funeral director Robert Francis Wright
(b) Address 727 Augusta St

JUN 11 1947 (Date rec'd by Registrar) [illegible]

V3 153

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 1947, at 4:39 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1947, to June 6 1947
and that I last saw h..... alive on ..... 19.....

Immediate cause of death Acute Intestinal Reflex — Duration

Due to ..... — 10 min.

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation? .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Louis A. Johnson M.D.
Address 2329 Guilford Date signed June 8 1947

G52169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G52169

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 318 E University Parkway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 318 E University Parkway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Richardson Buck

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Annie Wallace | 6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) 6/4/1856

8. AGE: Years: 91 | Months | Days: 6 | If less than one day: hr. min.

9. Birthplace: Va (Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business

FATHER 12. Name: Wm M. Buck
13. Birthplace: Va

MOTHER 14. Maiden Name: Eliza A. Ashby
15. Birthplace: Va

16 (a) Informant: Mrs. Mary B. Rowe
(b) Address: 318 E University Pkwy

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/13/47 (month) (day) (year)
(c) Cemetery or crematory: Grant Royal
Location: Virginia

18 (a) Funeral director: J. Dabney Jones
(b) Address: 131 E Light St.

JUN 11 1947 (Registrar) Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1947 at 6 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 1945 to June 10 1947 and that I last saw him alive on June 9 1947.

Immediate cause of death: Cerebral Hemorrhage — Duration: 1 Hr

Due to: Generis-Sclerosis — Duration: Gradual

Due to: Myocardiation

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. W. Brady, M.D.
Address 140 S Parkwood Date signed 6/11/47

G52170

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G52170

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1519 Cole St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1519 Cole St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Stein

3 (b) If veteran, name war None

3 (c) Social Security Account No. 715-10-3937

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Clara J. Stein

6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) May 15 1877

8. AGE: Years 70 | Months 0 | Days 25 | If less than one day ____ hr. ____ min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Clara J. Stein
(b) Address 1519 Cole St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 12 1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto Md

18 (a) Funeral director C. B. M. Walter
(b) Address Pratt & Tucker Sts

JUN 11 1947 (Date received by registrar) (b) Funeral director's signature

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 1947, at 11 05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 1 1946 to June 9 1947, and that I last saw h[illegible] alive on June 9 1947.

Immediate cause of death Pulmonary Tuberculosis — Duration unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nathan Racusin M. D.
Address 206 S. Gilmor St. Date signed 6-10-47

X

G52171

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G52171

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1521 N Patterson Park Ave
(c) Hospital or institution: Gr
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 68 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1521 N O P K ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles H Miller.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Rose E Miller

6 (c) If alive, give age | 86 years

7. Birth date of deceased (mo., day, yr.) Sept 20 (1864)

8. AGE: Years	Months	Days	If less than one day
78 (82)	8	20	hr. min.

9. Birthplace Germany (Town, county and State)

10. Usual Occupation Brick Layer

11. Industry or business Contractor.

FATHER
12. Name Dont Know
13. Birthplace Germany

MOTHER
14. Maiden Name Dont Know
15. Birthplace Germany

16 (a) Informant Catherine Cline
(b) Address 1014 N O P K ave

17 (a) Burial (b) Date thereof June 13
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto City Cem
Location

18 (a) Funeral director Hillrich Funeral Home
(b) Address 2008 Eastern Ave

19 (a) Date received by Registrar JUN 11 1947 (b) Registrar Washington Williams M.D.

V S 130

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10th 1947, at 5 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1947 to June 10 1947
and that I last saw deceased alive on June 10 1947

Immediate cause of death Coronary Thrombosis

Due to Chronic Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

Duration	
6/10/47	
7/1946	

PHYSICIAN
Underline the cause to which death should be charged, statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Pylaer M.D.
Address 1014 N O P K ave Date signed 6/10/47

G52172 D

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G52172 ✓ Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ...
(c) Hospital or institution Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) ...
(e) Length of stay in Baltimore (yrs., mos., or days) ...

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ...
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 Eutaw [redacted]
(If rural give location)
(e) Citizen of foreign country? No
If yes, name country ...

3 (a) FULL NAME James H. Orr

3 (b) If veteran, name war ...
3 (c) Social Security Account No. ...

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Edith
6 (c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) 2-11-1895

8. AGE: Years 52 | Months 3 | Days 29 | If less than one day ... hr. ... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business ...

FATHER
12. Name James Orr
13. Birthplace Md.

MOTHER
14. Maiden Name Sally Reynolds
15. Birthplace Md.

16 (a) Informant Mrs. Edith Orr
(b) Address 620 N. Bruce St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-13-47 (month) (day) (year)
(c) Cemetery or crematory Lt. Moriah
Location Hampden, Baltimore

18 (a) Funeral director George A. Fogler
(b) Address Hilton Ave. & Fayette St.

(Date rec'd by Registrar) JUN 11 1947 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9, 1947, at 11:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 8, 1947 to June 9 1947 and that I last saw him alive on June 9, 1947

Immediate cause of death	Duration
Pulmonary edema	
Due to Myocardial failure	
Due to Overwhelming infection	
Other Conditions Pulmonary tuberculosis;	

(Include pregnancy within 3 months of death)

Date of operation ...
Major findings of operation: ...
of autopsy Pulmonary edema & tuberculosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ...
(b) Date of occurrence ... at ... M
(c) Where did injury occur? ...
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work? ...
(Specify type of place)
(e) Means of injury ...

23. Signature Sidney Green M. D.
Address Sinai Hospital Date signed 6-10-47

X

G52173 ①

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G52173

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 33 Bishop's Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gerard J. Schatz

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Married

6 (b) Name of husband or wife Margaret
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6, 1905

8. AGE: Years	Months	Days	If less than one day
41	8	1	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Diaper
11. Industry or business

MOTHER FATHER
12. Name Christopher E. Schatz
13. Birthplace Md.
14. Maiden Name Annie Stempf
15. Birthplace Md.

16 (a) Informant Richard Schatz, Son
(b) Address 33 Bishop's Lane.

17 (a) Burial (b) Date thereof 6-12-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director George A. Fooley
(b) Address Fulton Ave & Fayette St.

19 JUN 11 1947 (b) Huntington for Williams, M.D.
(Registered by Registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/7 1947, at 1:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Rupture Rt. Lung
Hemo-pneumo thorax.

Due to Multiple fractures of Ribs, Rt.

Other Conditions Dislocation 3rd Cervical Vertebrae, Calcification of pericardium
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-3-47 at 1:30 P.M.
(b) Where did injury occur? 33 Bishop's Lane
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial = Home (While at work?) yes
(d) Means of injury Fell off a ladders

23. Signature Earl L. Kroyer M.D.
Medical Examiner.
Date signed 6-9-47

G52174

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

Registered No. G52171

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland ✓
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 508 W. Preston St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Walker

3 (b) If veteran, name war: No
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife: Rosa Walker
6 (c) If alive, give age 60 years
7. Birth date of deceased (mo., day, yr.) 7/22/1892
8. AGE: Years 54 Months 10 Days 10 If less than one day hr. min.
9. Birthplace Lanesberg Va. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Rosalee Walker
(b) Address 508 Preston Street

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 6-11-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Balto. County Md.

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) Date received JUN 11 1947 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/7/47, at 2:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 22 1947 to 6/7 1947 and that I last saw h[illegible] alive on 6/7 1947.

Immediate cause of death	Duration
Congestive Heart Failure	
Due to Hypertensive Cardio Vascular Renal Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frederick C. Smith M. D.
Address 1614 Division St. Date signed 6-10-47

VS 150

G52175

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G52175

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address /
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) 80? yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 12
(c) City or town Baltimore County
(If outside city or town limits, write RURAL and give town)
(d) Street No. 504 Annesley Rd. Annapolis
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wesley G Sweenarner

3 (b) If veteran, name war W

3 (c) Social Security Account No. None

4 Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Emma

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 11. 1869

8. AGE: Years 87 Months 8 Days 29 If less than one day hr. min.

9. Birthplace Trenton (Town, county, and state) N.J.

10. Usual Occupation Clothing Designer

11. Industry or business

FATHER
12. Name John Sweenarner
13. Birthplace Va

MOTHER
14. Maiden Name Wilhelmina Lee
15. Birthplace Va

16 (a) Informant Mrs Elsie V Walters
(b) Address 504 Annesley Rd

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 6/12/47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Gilbert & Sons
(b) Address 1219 E Fort Ave

19 JUN 11 1947 (Date rec'd by registrar) (b) Huntington Hillmeyer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/10/1947, at 10 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/22/1947 to 6/10/1947 and that I last saw h. alive on 6/10/1947.

Immediate cause of death Cardiac Respiratory Failure — Duration

Due to Dehidratation

Due to Old Age - Arteriosclerosis

Other Conditions Fracture of Femur

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 5/22/47 at 8a.m. A.M.
(c) Where did injury occur? Baltimore Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? At Home (Specify type of place) While at work? No
(e) Means of injury Fall to floor

23. Signature Leo A. Wilson, Jr. M. D.
Address University Hosp. Balt Md. Date signed 6/10/47

VS 150 Earl L. Riley, Md. To be approved by Medical Examiner

G52176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1248

✓ G52176 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2422 Calverton Hgts. Ave.
(c) Hospital or institution:

16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2422 Calverton Hgts. Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM E. SEIBEL, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Laura A. Seibel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 14, 1868

8. AGE: Years	Months	Days	If less than one day
78	5	25	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired Chief CarpentersMate
11. Industry or business U. S. C. G.

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mr. Wm. E. Seibel, Jr.
(b) Address 2422 Calverton Heights Ave.

17 (a) Burial (b) Date thereof 6/2/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) Date received by Registrar JUN 11 1947 (b) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9, 1947, at 11:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1947 to June 1947, and that I last saw h[illegible] alive on 8 June 1947.

Immediate cause of death Cerebral hemorrhage — Duration 30 minutes

Due to arteriosclerosis

Due to Chronic nephritis

Other Conditions Cirrhosis of liver

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H H Bayless M. D.
Address 1600 Wilkens Av Date signed 6/9/47

1312

G52177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G52177

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct, age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 508 Old Orchard Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 508 Old Orchard Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME H. MABEL WINCHESTER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Clifford B. Winchester
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 23, 1883

8. AGE: Years	Months	Days	If less than one day
63	6	15	hr. min.

9. Birthplace Balto.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Washington H. Nicholson
13. Birthplace Balto.

MOTHER
14. Maiden Name Cornelia Cartier
15. Birthplace Whitehall, N. Y.

16 (a) Informant Mrs. George Geyer
(b) Address 266 Sussex Drive, Manhasset

17 (a) Entombment (b) Date thereof 6/11/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Mausoleum
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 JUN 11 1947 (Date received by registrar) Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8, 1947, at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 1947 to June 8 1947.
and that I last saw h e alive on June 6 1947.

Immediate cause of death	Duration
a Malignancy - Endometrium	1 yr 7 mos
b Lungs - Pulm - Metastases	
Due to Primary Site not determined	
Due to Cachexia - dehydration	4 or 5 days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frederick V. Bowles M. D.
Address 723 Medical Arts Bldg Date signed 6-10-47

G52178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G52178

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 312 N. Pulaski St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 312 N. Pulaski St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL J. SCHENKEL

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Lydia E. Schenkel (nee Reightler) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19, 1866

8. AGE: Years	Months	Days	If less than one day
80	10	19	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John Schenkel
13. Birthplace Germany

MOTHER
14. Maiden Name - Hunt
15. Birthplace France

16 (a) Informant Mrs. F. G. Cromer, daughter
(b) Address 3112 Brighton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/11/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 [illegible] (b) [illegible] Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8, 1947, at 10:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1947 to 6/8 1947 and that I last saw h[illegible] alive on 6/7 1947.

Immediate cause of death	Duration
Cerebral Thrombosis	?
Due to Arteriosclerotic Cardio-Vascular disease.	
Due to	
Other Conditions Senility	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 400 N. Payson St. Date signed 6/9/47

G52179

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

Registered No. G52179

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto. City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1407 E. Biddle (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Eugene) Lorraine J. Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife Daniel Brown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1922.

8. AGE: Years	Months	Days	If less than one day
24	5	15	hr. min.

9. Birthplace Cumberland Co. Va. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Edward Jones
13. Birthplace Va.

MOTHER
14. Maiden Name Lucille Hatchett
15. Birthplace Va.

16 (a) Informant Edward Jones
(b) Address 1407- E. Biddle Street.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof June 12 '47 (month) (day) (year)
(c) Cemetery or crematory
Location Cumberland Co. Va.

18 (a) Funeral director Mrs. Ruth A. Elliott & Dept
(b) Address 1129 N. Caroline Street

(c) (Signature of funeral director) Huntington Williams M.E. Registrar

JUN 11 1947

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/9 1947 at 5:30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Stab-wound of left chest, diaphragm, and colon.

~~Due to~~ Peritonitis
Empyema

~~Other Conditions~~ Pericarditis
Atalectasis left lung.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6/8/47 at 5 A.M.
(b) Where did injury occur? Front Steps: 1407 E. Biddle
(c) Did injury occur at home, on farm, industrial place, in public place? Outside of home While at work? No
(d) Means of injury Stabbed with knife

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 6-10-47

G52180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133a

Registered No. G52180

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22d
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 236 S Clinton St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Pauline Keller Clark

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	M

6 (b) Name of husband or wife Mr. George Clark
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 22, 1882

8. AGE: Years	Months	Days	If less than one day
64 6 5	3 8	12 18	hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation housework
11. Industry or business none

FATHER
12. Name Theodore Keller
13. Birthplace Germany

MOTHER
14. Maiden Name Walberg Albus
15. Birthplace Germany

16 (a) Informant husband
(b) Address 236 S Clinton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/10/47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cemetery
Location German Hill Rd

18 (a) Funeral director John J. Duda
(b) Address 2826 Hudson St
(c) [illegible] Huntington Williamson, W. Va.

JUN 11 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1947, at 10 20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 29 1947, to June 10 1947 and that I last saw h[illegible] alive on 6-10 1947.

Immediate cause of death Coronary Thrombosis — Duration

Due to Renal failure

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James V. Lucas M. D.
Address Henry Hosp Date signed 6-10

G52181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G52181 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 217 N. Pine St.
(c) Hospital or institution: 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimpre (If outside city or town limits, write RURAL and give town)
(d) Street No. 217 N. Pine St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lizzie Sample

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 27, 1889

8. AGE: Years	Months	Days	If less than one day
58	4	10	hr. min.

9. Birthplace Davidson Wharf, Va.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name John Allen Sample.
13. Birthplace Davidson Wharf, Va.

MOTHER
14. Maiden Name Annie Bivins
15. Birthplace Davidson Wharf, Va.

16 (a) Informant Edith Sample.
(b) Address 217 N. Pine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-11-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Thos. Peter R. Williams
(b) Address 822 N. Schroeder St.

JUN 11 1947 Huntington Williams, MD
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 June 1947, at 9 A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardio-vascular Renal Disease

Due to

Other Conditions decubitus Ulcers, severe.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammerer, Jr. M.D.
Medical Examiner.
Date signed 9 June 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 191

C52182

JL - 111151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

837

Registered No. C52182

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1023 Vine St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Smith

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 18, 1889

8. AGE: Years	Months	Days	If less than one day
58	4	20	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ? ?
13. Birthplace ?

MOTHER
14. Maiden Name Ellen Smith
15 Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 6-12-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder
JUN 11 1947 Huntington Williams Mortuary
(Date received by Registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 1947, at 1:45A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 3 1947 to June 8 1947, and that I last saw h im alive on June 8 1947.

Immediate cause of death	Duration
Circulatory Failure	
Due to Lobular Pneumonia	
Due to Arteriosclerosis	
Other Conditions Rt. Hemiplegia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature W. R. Dearborn
Address Balto. City Hosp. Date signed 6-8-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

T52183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH . 13B

G52183 ✓ Registered No.

No. 110373

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 8
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 204 N. Schroeder St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Jordan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband ~~xxxxx~~ Joseph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10th, 1919

8. AGE: Years	Months	Days	If less than one day
28	1	-	hr. min.

9. Birthplace S. C
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jackson Bennett
13. Birthplace S. C

MOTHER
14. Maiden Name Mary Caraway
15. Birthplace N. C.

16 (a) Informant Baltimore City Hospital
(b) Address 4940 Eastern Ave (Records)

17 (a) Shipped (b) Date thereof 6-11-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cheraw
Location S. C.

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) JUN 11 1947 (Local registrar) Huntington Williams M.D.
(b)

V S 190

MEDICAL CERTIFICATION A.M

20. DATE OF DEATH June 10th 1947 19 at 7.00 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 2nd 1947 to June 10th 1947 and that I last saw h er alive on June 10 1947

Immediate cause of death	Duration
Bilateral	3 months
for advanced Pulmonary Tuberculosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. E. Wright M. D.
Address Date signed 6-10-47

X

G52184

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

G52184 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Baltimore Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 820 W. Franklin (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert Jefferson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 26, 1923

8. AGE: Years	Months	Days	If less than one day
23 24	8	13	hr. min.

9. Birthplace: Lynchburg, S.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Lonnie Jefferson
13. Birthplace: Lynchburg, S.C.

MOTHER
14. Maiden Name: Elizabeth McGill
15. Birthplace: Lynchburg, S.C.

16 (a) Informant: Elizabeth Jefferson
(b) Address: 820 W.Franklin Street.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-12-1947 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location

18 (a) Funeral director: Mrs. Kate R. Williams
(b) Address: 322 N. Schroeder St.

19 JUN 11 1947 Registered by: Huntington Williams

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/9/1947, at 4 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH: Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6/7/47 at 3:20 P.M.
(b) Where did injury occur? 2900 Waterview Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury: Drowned while Swimming

23. Signature: Carl L. Rogers M.D. (Medical Examiner)
Date signed 6-10-47

G52485

BALTIMORE CITY HEALTH DEPARTMENT

TN. 109522

CERTIFICATE OF DEATH 55E

G52485 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2m 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2420 Frances St Zone 17
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Col

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband Charles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11th 1896

8. AGE: Years 51 | Months 1 | Days 27 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation domestic

11. Industry or business

FATHER
12. Name James Greenfield (D
13. Birthplace Maryland

MOTHER
14. Maiden Name Maria Stamp (D
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/8/47 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Md

18 (a) Funeral director Geo. G. Nelson
(b) Address 1303 Preastman St.

JUN 11 1947 (Date rec'd by registrar) (b) Washington Heights Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8th 1947 at 2.15 A.M. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 29th 1947 to June 8th 1947 and that I last saw her alive on June 8th 1947

Immediate cause of death: Carcinomatosis abdomen & Liver — Duration 4 mo.

Due to:

Due to Primary site: — " "

Other Conditions Carcinogenic Carcinoma

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Robinson Jr. M. D.
Address Balt. City Hosp. Date signed 6/9/47

G52186

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G52186 Registered No. 1314

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 834 Cold Spring Lane
(b) Street address
(c) Hospital or institution: Balto Asylum

(d) Length of stay in hospital or inst. (yrs., mos., or days) mo
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town E Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 834 Cold Spring Lane (If rural give location)
(e) Citizen of foreign country? Balto (Yes or No)
If yes, name country

3 (a) FULL NAME Robt Diggs

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex M | 5. Color or race negro | 6 (a) ~~Single, married~~, widowed, or divorced. - 48

6 (b) Name of husband or wife Elizabeth Diggs

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/25/1890

8. AGE: Years 56 | Months Jun | Days 8 27 13 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Ned Diggs
13. Birthplace Md

MOTHER 14. Maiden Name Rosetta
15. Birthplace Md

16 (a) Informant Leroy Diggs
(b) Address 834 Cold Spring Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 11 47 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. W. Kelson
(b) Address 1303 Presstman St

19 (a) (Signature of local registrar) (b) Washington Williams M.D. (Address)

JUN 1 1947

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-8-1947, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-28-1947 to 6-8-1947, and that I last saw h— alive on 6-7-1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 hr
Due to Hypertension, Myocarditis	
Due to Nephritis	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm R Boykin M.D.
Address 1133 Mount Date signed 6/10/47

BOYKIN

G52187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82

Registered No. G52187

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 109 S. Washington St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) Y
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 109 S. Washington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Kotecki

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 13 1900

8. AGE: Years 46 | Months 10 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Ignatius Kotecki
13. Birthplace Poland

MOTHER
14. Maiden Name Anna Osler
15. Birthplace Poland

16 (a) Informant Mrs. Anna Kotecki
(b) Address 109 S. Washington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-13-47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 418 S. Chester Street

19 JUN 11 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

VS 130

MEDICAL CERTIFICATION 445

20. DATE OF DEATH June 9, 1947, at A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10 1946 to June 9 1947 and that I last saw h[illegible] alive on June 8 1947

Immediate cause of death Fredericks Ataxia
Cause conditions Incoordination

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Andrew Hutchinson M. D.
Address 257 E Eastern Ave, Date signed

X

G52188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

G52188 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2231 Ruskin Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2231 Ruskin Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Madeline Ward

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife John Ward
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug, 26, 1893

8. AGE: Years	Months	Days	If less than one day
53	9	13	hr. min.

9. Birthplace Chicago (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Federal Gov.

FATHER
12. Name Michael H. Moroney
13. Birthplace Iowa

MOTHER
14. Maiden Name Nellie A. Lovett
15. Birthplace Ireland

16 (a) Informant Miss Moroney
(b) Address 2231 Raskin Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 12, 1947 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 East Biddle St

19 JUN 11 1947 (Registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-9- 1947, at 11.a M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-7- 1947, to 6-9 1947, and that I last saw h[illegible] alive on 6-9- 1947.

Immediate cause of death Acute Dilatation of Heart — Duration .24 hrs.
Due to Hypertension — several year.
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lt (jg) C. Blake
Address Med. Arts Bldg Date signed 6-10-47 M. D.

Dr [illegible] Med. Arts

G52189

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 46 B

Registered No. G52189

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — North Broadway
(b) Street address — Church Home & Hosp
(c) Hospital or institution: ↗

(d) Length of stay in hospital or inst. (yrs., mos., or days) 34 days
(e) Length of stay in Baltimore (yrs., mos., or days) 34 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Florida (b) County —
(c) City or town Palm Beach
(If outside city or town limits, write RURAL and give town)
(d) Street No. 281 Palmo Way
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3 (a) FULL NAME Francis E Wedge

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Sarah Wedge
6 (c) If alive, give age? years

7. Birth date of deceased (mo., day, yr.) april 9 1893

8. AGE: Years	Months	Days	If less than one day
54	2 1	1	hr. min.

9. Birthplace Penn.
(Town, county, and state)
10. Usual Occupation Gardener
11. Industry or business

FATHER
12. Name Theodore Wedge
13. Birthplace England

MOTHER
14. Maiden Name Annie Killan
15. Birthplace Penn.

16 (a) Informant Mrs Sarah Wedge
(b) Address 281 Palms Way Palm Beach Fla.

17 (a) removal (b) Date thereof 6/11/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mok Palm Beach
Location West Palm Beach, Florida

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) JUN 11 1947 (Date received by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-10 1947, at 7:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-8 1947 to 6-10 1947, and that I last saw him alive on 6-10 1947

Immediate cause of death	Duration
Pancreatic necrosis	20 days
Due to Partial Pancreatectomy & Partial Gastrectomy	
Due to Adeno Carcinoma of the Stomach	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 5-22-47
Major findings of operation: adeno carcinoma of Stomach
of autopsy: Pancreatic Necrosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dorence L Lindsey M.D.
M. D.
Address Church Home & Hosp Date signed 6-11-47

X

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G52190 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Katon Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town CATONSVILLE Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 20 No. Rolling Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Katherine Schulbe (Katherine Elizabeth Schulbe)

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: George P. Schulbe

6 (c) If alive, give age: 78 years

7. Birth date of deceased (mo., day, yr.): 10 | 3 | 1873.

8. AGE: Years: 73 | Months: 8 | Days: 8 | If less than one day: hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER
12. Name: William Hofmeister
13. Birthplace: Germany

MOTHER
14. Maiden Name: Fredericke Badongiere
15. Birthplace: Maryland

16 (a) Informant: George P. Schulbe
(b) Address: 20 N. Rolling Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 6/13/47 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC
(b) Address: NORTH AVE. & BROADWAY

19 (a) Date received: JUN 11 1947 (b) Registrar: Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6 | 11 | 47 19 , at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 6/11/47 19 , and that I last saw h[illegible] alive on 6/10/47 19 .

Immediate cause of death: Cardiac failure - pleurisy pneumonia
Due to: [illegible] & arteriosclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Duration:

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: [illegible]
Address: [illegible] Date signed: 6/11/47

X

G52191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G52191 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 326 E. LAFAYETTE St
(c) Hospital or institution:
17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 31 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 326 E. LAFAYETTE AVE
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME DANIEL ALLEN JOHNSON

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife ANNIE E. JOHNSON
6 (c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) OCT. 3 1868

8. AGE: Years	Months	Days	If less than one day
78 79	8	6	hr. min.

9. Birthplace LEITERSBERG, MD
(Town, county, and state)
10. Usual Occupation CLERK
11. Industry or business

FATHER
12. Name WILLIAM JOHNSON
13. Birthplace S.C.

MOTHER
14. Maiden Name BARBRA LOWMAN
15. Birthplace MD

16 (a) Informant ANNIE E. JOHNSON
(b) Address 326 E. LAFAYETTE

17 (a) BURIAL (b) Date thereof JUNE 12 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory ROSEHILL
Location HAGERSTOWN, MD.

18 (a) Funeral director KRAISS FUNERAL HOME
(b) Address HAGERSTOWN, MD

19 1947 (b) Filed by registrar Huntington for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 - 1947 at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 17 - 1946 to June 8 - 1947 and that I last saw him alive on June 8 - 1947

Immediate cause of death	Duration
Myocardial failure,	8 weeks
Due to Chronic Myocarditis	several years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 117 S. Maryland Ave Date signed 6/7/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G52192 Registered No. 14747

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1613 Waldo St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 71

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1613 Waldo St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Albert Hall

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Mary O. Hall
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) 10-21-1876

8. AGE: Years 70 | Months 7 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Isabella Frye
15. Birthplace Anne Arundel Co.

16 (a) Informant Mary O. Hall
(b) Address 1613 Waldo St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 13-1947 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem.
Location Baltimore Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bolantty ave

19 (a) [illegible] Huntington Williams, M.D.
[illegible] 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1947, at 8:01 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1947, to June 9 1947, and that I last saw him alive on June 9 1947.

Immediate cause of death — Duration
Cerebral Hemorrhage — 3 days
Due to Arterio-Sclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ronald Blinkhorn M. D.
Address 501 Cherry Hill Rd Date signed 6-10-47

X

G52193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G52193 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 2601 Hollman Rd - Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Keys -

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single -

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-28-79

8. AGE: Years	Months	Days	If less than one day
68	3	9	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Laborer -
11. Industry or business

FATHER
12. Name David Keys
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 11-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location Brooklyn, Md
18 (a) Funeral director Elroy D. Wilson
(b) Address 1000 Baltimore Ave
19 (a) JUN 12 1947 (b) (Registrar) Registrar

VS 150

Huntington Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9, 1947, at 10 H. P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 31 1947, to June 9 1947 and that I last saw him alive on June 9 1947.

Immediate cause of death Pulmonary Tuberculosis, bilateral, Apical. Tuberculous Pneumonia - Left up lobe — Duration 8 wks

Due to — 2 Mos

Other Conditions Arteriosclerotic heart disease, cardiac insufficiency — 3 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Eugene Lazzeri Jr M. D.
Address Johns Hopkins Hosp Date signed June 10 1947

X

G52494

missing

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G52195

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G52195
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 267 Calvert st. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Daniels

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 69 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore (town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Mr. Harrington

(b) Address 267 Calvin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-12-47 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary R. R. Co

Location

18 (a) Funeral director Rayner Sanders

(b) Address 1417 E. Preston St. Baltimore, Md.

19 (a) JUN 11 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 June 1947, at 12:30 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature H. M. H. Rammer, Jr. M.D. Medical Examiner.

Date signed 9 June 1947

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52196

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 131a

Registered No. G52196

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) less than 1 day
If not in hospital, give length of time at present address
(e) Length of stay in Baltimore (yrs., mos., or days) less than 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State DC (b) County
(c) City or town Washington
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5521 Chevy Chase Parkway
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Elbert Jefferson Harris

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 20, 1862

8. AGE: Years 85 | Months 4 | Days 22 | If less than one day hr. min.

9. Birthplace Carroll Co. Va.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER 12. Name Robert Harris
13. Birthplace ?

MOTHER 14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Removal & Burial (b) Date thereof 5/14/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Fort Lincoln
Location D. C.

18 (a) Funeral director William Cook
(b) Address 1517 F. Road N.E. Washington, D.C.

19 (a) JUN 12 1947 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1947, at 10:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1947 to June 11 1947, and that I last saw h[illegible] alive on June 11 1947.

Immediate cause of death Arteriosclerotic heart disease with cardiac failure. Arteriosclerotic nephritis. — Duration: IN DEFINITE

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 6/11/47

VS 150

X

C52197 Bk # J-68027 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH ✓ 114E Registered No. C52197

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Lightst
(c) Hospital or institution: So Balto Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13da
(e) Length of stay in Baltimore (yrs., mos., or days) Same

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 117 E Churchill St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Basil E. Bowen
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S.

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 8-Jan 12, 93

8. AGE: Years	Months	Days	If less than one day
54	4	28	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Hezekiah Rubell
13. Birthplace Va.

MOTHER 14. Maiden Name Emma Burton Bowen
15. Birthplace Md.

16 (a) Informant Emma Burton Bowen
(b) Address 117 E. Churchill St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/13/47 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie Md

18 (a) Funeral director Pethopp & Son
(b) Address 129 S. Paca St

19 JUN 12 1947 Registrar Washington Williams, M.D.

MEDICAL CERTIFICATION P

20. DATE OF DEATH 6-10 1947 at 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-27 1947 to 6-10 1947 and that I last saw him alive on 6-10 1947

Immediate cause of death Respiratory failure — Duration

Due to Atelectasis Rt Lung

Due to Obstruction Rt Bronchus Bronchus. — 1 year

Other Conditions Malignant Hypernephroma
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Atelectasis Rt Lung

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Brooke Wells M.D.
Address 1211 Lightst, Date signed 6-11-47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G52198 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 502 N. Payson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 502 N. Payson (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCIS L. BENNETT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	D.

6 (b) Name of husband or wife Annie Deiner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 29th 1884

8. AGE: Years	Months	Days	If less than one day
63	4	11	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Bar Tender
11. Industry or business Abe's Cafe
FATHER 12. Name George L. Bennett
13. Birthplace Baltimore, Md.
MOTHER 14. Maiden Name Lydia Rodenmyer
15. Birthplace Baltimore, Md.
16 (a) Informant Records
(b) Address Bon Secours Hospital
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/13/47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.
18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St
19 JUN 12 1947 (Date rec'd by registrar) Livingston Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10, 1947, at 3:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 7, 1947. to June 10, 1947. and that I last saw ~~he~~ she alive on June 10, 1947.

Immediate cause of death	Duration
Cardiac failure	
Due to Hypertensive cardio-vascular disease.	
Due to	
Other Conditions	

(Includes pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. L. Guardella
Address Bon Secours Hosp. Date signed M. D. 6-10-47.

VS 180

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

652199 BC# 280388 BALTIMORE CITY HEALTH DEPARTMENT Registered No. 652199

CM. 111117 CERTIFICATE OF DEATH √159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 4 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1408 N. Bethel ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lipscomb Baby Girl Delores

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2 - 1947

8. AGE: Years	Months	Days	If less than one day
0	0	4	hr. min.

9. Birthplace MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Worington Lipscomb
13. Birthplace MD.

MOTHER
14. Maiden Name Delores Thomas
15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Cremated (b) Date thereof June 7th 1947
Burial, cremation, or removal (month) (day) (year)
(c) Name of cemetery or crematory Baltimore City Hosp.
Location 4940 Eastern Ave (Records)

18 (a) Funeral director
(b) Address

19 (a) JUN 12 1947 Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 - 1947, 1.00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1947, to June 6- 1947, and that I last saw her alive on June 6 - 1947

Immediate cause of death	Duration
Cardiac Failure	2 days
Due to Over-sedation of Mother	3 days
Due to	
Other Conditions Prematurity	3 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Julian P. Griffin M. D.
Address Balt. City Hosp. Date signed 7 June 47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C52500

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 1937

Registered No. C52500

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Woodlawn (If outside city or town limits, write RURAL and give town)
(d) Street No. Ridge Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country -

3 (a) FULL NAME Laura Robinson

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife: Ralph Raymond Robinson
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Nov 8 1889

8. AGE: Years	Months	Days	If less than one day
57	7	2	hr. ..... min.

9. Birthplace Fredericksburg Va (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business -

FATHER
12. Name Amos G Raines
13. Birthplace Stafford County Va

MOTHER
14. Maiden Name Sarah E Snellings
15. Birthplace Stafford Co Va

16 (a) Informant Ralph R Robinson
(b) Address Ridge Rd Woodlawn Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 13'47 (month) (day) (year)
(c) Cemetery or crematory Reisterstown Meth Cem
Location Reisterstown Md
18 (a) Funeral director Wm Berryman & Sons
(b) Address Reisterstown Md

19 JUN 12 1947 Thurlington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10, 1947 at 1.05 p M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2, 1947 to June 10, 1947 and that I last saw her alive on June 10, 1947

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Hypertensive Cardio-vascular disease	
Due to	
Other Conditions Cardiac Failure Grade IV	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address [illegible] Date signed 6/10/47

VS 150

X

G52501

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G52501

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1647 Cliftview Ave.
(c) Hospital or institution:
(d) Length of stay in hospit (yrs., mos., or days)
(e) Length of stay in Baltim (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1647 Cliftview Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Joseph Vaeth

3 (b) If veteran, name war —
3 (c) Social Security Account No. 213-28-4504

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Emma M. Vaeth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1, 1894

8. AGE: Years	Months	Days	If less than one day
52	11	9	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Frank L. Vaeth
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary E. Bauer
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Emma M. Vaeth
(b) Address 1647 Cliftview Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 13/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto. Md.

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St.

19 JUN 12 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10th, 1947, at 5:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7th Jun. 1947 to 10 Jun 1947 and that I last saw him alive on 9 Jun 1947

Immediate cause of death Cerebral Hemorrhage — Duration 3 days
Due to Hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Daniel Ehrlich
Address 731 N. Balto St. Date signed 11 Jun 47 M

VS 150

G52502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G52502 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hosp. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2111 Clifton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca BROOKMAN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Solomon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Abraham

13. Birthplace Russia

MOTHER 14. Maiden Name Sarah

15. Birthplace Russia

16 (a) Informant Samuel Miller

(b) Address 1609 N. Payson St

17 (a) Burial (b) Date thereof 6-13-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Balt. Pike & Hamilton Ave

18 (a) Funeral director Jack Levine Inc

(b) Address 1139 E. Baltimore St

JUN 12 1947 (b) Huntington Williams Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/13 1947, at 4:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/11 1947 to 6/13 1947, and that I last saw h[illegible] alive on 6/11 1947.

Immediate cause of death Cerebral vascular accident, anteriosclerotic hypertension

Due to cardio vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stanley N. Goff

Address Sinai Hosp Date signed 6/12/47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52503
AB-107783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G52503

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 15-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4mos-18days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2117 Herbert Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Frances Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Married

6 (b) Name of husband or wife Albert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 14- 1870

8. AGE: Years	Months	Days	If less than one day
77	4	25	....hr. ....min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Edward Smith
13. Birthplace ?

MOTHER
14. Maiden Name Ann Temple
15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-12-47 (month) (day) (year)
(c) Cemetery or crematory Good Shepherd
Location Howard Co., Md.

18 (a) Funeral director J. Howard Strong
(b) Address 3207 W. North Ave.

19 (a) JUN 12 1947 Huntington Williamson

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 1947, at 10.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-21 1947, to 6-9 - 1947, and that I last saw her alive on 6-9- 1947

Immediate cause of death	Duration
Carcinoma of Cecum	2 years
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 7-13-46
Major findings of operation: Abscess
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maurice M. Levy, M.D.
Address Baltimore City Hosp. Date signed 6-10-47

V S 150

G52504 Pitts

EDNA MAE Pitts

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

Registered No. G52504

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Carrollton St.
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 440 Orchard St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edna Mae Pitts

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mr. Lindsie Pitts
6 (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) 3/4/05

8. AGE: Years 42 | Months 3 | Days 7 | If less than one day ... hr. ... min.

9. Birthplace Northumberland Co. Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name John Williams
13. Birthplace Va.

MOTHER
14. Maiden Name Vaene Bell
15. Birthplace Va.

16 (a) Informant Mr. Lindsai Pitts
(b) Address 440 Orchard St

17 (a) D (Burial, cremation, or removal) (b) Date thereof 6-15-47 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Balto Co. Md.

18 (a) Funeral director Samuel M. Sullivan & Son
(b) Address 1814 N. Arlington Ave.

19 JUN 12 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/11/47 1947, at 6:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/29 1947, to 6/11 1947 and that I last saw h[illegible] alive on 6/11/47 1947.

Immediate cause of death: Respiratory Failure — Duration: 1-2 Hours

Due to: Toxemia — 1 Week

Due to: Pari-tonitis — 10 days

Other Conditions: Incomplete obstruction post Operation (Include pregnancy within 3 months of death) — 10 days

Date of operation 6/3/47

Major findings of operation: Remarkable [illegible]

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James J. Shanks M. D.
Address St. Josephs Hosp. Date signed 6/11/47

VS 150

X

G52505

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G52505

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: Monument & Rutland Ave 13-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2314 Whittier Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isaac Levinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Birdie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15, 1875

8. AGE: Years	Months	Days	If less than one day
72	1	28	hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Merchant
11. Industry or business

FATHER
12. Name Israel Levinson
13. Birthplace Russia

MOTHER
14. Maiden Name Rose Klein
15. Birthplace Russia

16 (a) Informant Celia Levinson
(b) Address 2314 Whittier Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 12, 1947 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Cem
Location 3600 E Baltimore St

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) Filed in registry JUN 12 1947 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1947; about 12½ M

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1947 to June 12 1947, and that I last saw him alive on June 12 1947.

Immediate cause of death Cardiac failure — Duration

Due to Arteriosclerotic Heart Disease

Due to Generalized arteriosclerosis

Other Conditions Enlarged prostate

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sidney Green M. D.
Address Sinai Hosp Date signed 6/12/47

G52506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G52506

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5306 Chandler Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5306 Chandler Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Clarence White, Jr. Clarence Charles White, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-14-0364

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Virginia M. White

6 (c) If alive, give age 21 years

7. Birth date of deceased (mo., day, yr.) Nov. 24, 1924

8. AGE: Years	Months	Days	If less than one day
22	6	17	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Produce Manager
11. Industry or business Ch'd Food Stores

FATHER
12. Name Clarence White Sr.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Julia Emma Wright
15. Birthplace Salisbury, Md

16 (a) Informant Mrs. Clarence White, Jr.
(b) Address 5306 Chandler Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 14, 1947 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Miles L. Amoss
(b) Address 1610 Liberty Heights Ave. Huntington Williams, M.D.

19 JUN 12 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1947 at 6 P.M.

21. I certify that death occurred on the date above-stated; that I attended deceased from May 20 19 47 to June 11 19 47.
and that I last saw h[illegible] alive on June 11 19 47.

Immediate cause of death	Duration
Ventricular fibrillation	8 hr.
Due to Hematic subacute bacterial endocarditis	6 mo.+
Due to Chr. interstitial nephritis with hypertension	6 mo.+
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 1610 Liberty Hgts Ave. Date signed 6/11/47

VS 150

G52507

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1467

Registered No. G52507

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Duke Land & Rayner Ave
(c) Hospital or institution: West Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) 71 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3328 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joshua H. Johnston

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 212-07-5351

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife Agnes M. Johnston
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27, 1875

8. AGE: Years	Months	Days	If less than one day
71	10	13	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Retired Machinist

11. Industry or business & Toolmaker

FATHER
12. Name John H. Johnston
13. Birthplace Canada

MOTHER
14. Maiden Name Hannah Torrence
15. Birthplace Orange, Ireland

16 (a) Informant Mrs. Agnes Johnston
(b) Address 3328 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/14/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUN 12 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-10 1947, at 9:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-16 1947 to 6-10 1947, and that I last saw h. alive on 6-10 1947

Immediate cause of death	Duration
Pulmonary Edema	
Due to Bilateral Bronchial Pneumonia	
Septicemia - Aerobacter Aerogenes	
Due to Ileo-Pelvic Fistula	
Carcinoma Recto-Sigmoid	

Other Conditions Left Hydronephrosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Carcinoma Recto Sigmoid

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benjamin [illegible] M.D.
Address West Baltimore Date signed 6/11/47

VS 150

G52508

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

G52508 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2216 Poplar Grove St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 T
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2216 Poplar Grove St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CARLOTTA CHRISTMAN SANDERS

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife Charles Howe Sanders
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1884

8. AGE: Years	Months	Days	If less than one day
62	8	0	hr. min.

9. Birthplace Brooklyn, N. Y.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Edward A. Christman
13. Birthplace New York

MOTHER
14. Maiden Name Katherine Clark
15. Birthplace New York

16 (a) Informant Mr. William N. Sanders, son
(b) Address 2216 Poplar Grove St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/12/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Maus.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 JUN 12 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10, 1947, at 6 00 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1946 to June 10 1947, and that I last saw h alive on June 9 1947

Immediate cause of death	Duration
Terminal Bronchopneumonia	6 days
Due to Carcinoma of bladder	5 yrs
Due to Chronic Rheumatoid arthritis, severe.	25 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Daniel R Coburn M. D.
Address 2836 Wynnes Falls P. Way Date signed 6-11-47

V S 190

G52509

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G52509 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden + Madison Sts
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 12 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2215 Lake Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Reverend Reuben Young Nicholson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Altie B. Nicholson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 7, 1884

8. AGE: Years	Months	Days	If less than one day
62	8	3	hr. min.

9. Birthplace Olney, Md. (Town, county, and state)
10. Usual Occupation Minister (Methodist)
11. Industry or business

FATHER
12. Name William Nicholson
13. Birthplace Montgomery Co., Md.

MOTHER
14. Maiden Name Carrie Young
15. Birthplace Frederick, Md.

16 (a) Informant Mrs. Altie B. Nicholson wife
(b) Address 2215 Lake Ave. 13

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/13/47 (month) (day) (year)
(c) Cemetery or crematory St. Johns Cem
Location Olney, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 6-12 1947 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10th 1947, at 3.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 7th 1947 to June 10th 1947, and that I last saw him alive on June 10th 1947.

Immediate cause of death	Duration
Heart failure	
Due to Coronary occlusion	3 days.
Due to	
Other Conditions Terminal bronchopneumonia (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. E. González M. D.
Address Maryland Gen. Hosp. Date signed 6/10/47

G52510 Chisley 13B

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G58540

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REGISTRY RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 638 Smithson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 638 Smithson St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Chisley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age ___ years

7. Birth date of deceased (mo., day, yr.) Oct 25, 1926

8. AGE: Years	Months	Days	If less than one day
20	7	16	___ hr. ___ min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation House Work

11. Industry or business Day worker

FATHER
12. Name James Chisley
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Marie Carroll
15. Birthplace Baltimore Md

16 (a) Informant Mrs Marie Chisley
(b) Address 638 Smithson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/13/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. B. Kelso
(b) Address 1303 Pressman St

19 JUN 12 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-10-1947, at 1:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-23-1947, to 6-10-1947 and that I last saw h[illegible] alive on 6-10-1947.

Immediate cause of death Pulmonary Tuberculosis — Duration 2 Mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank A. Saunders M.D.
Address 1029 N. Stricker Date signed 6-11-47.

C52511

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. C52511

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 200 Monastry Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 ?
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 200 Monastry Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lazar Lichter
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Pearl
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1870
8. AGE: Years 77 Months Days If less than one day hr. min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation retired
11. Industry or business
FATHER 12. Name Chadoze
13. Birthplace Russia
MOTHER 14. Maiden Name Sarah
15. Birthplace Russia
16 (a) Informant Pearl Lichter
(b) Address 200 Monastry Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-12-47 (month) (day) (year)
(c) Cemetery or crematory Herring Run
Location Park Rd & Bowleys Lane
18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Baltimore St.
19 (a) Date received JUN 12 1947 Huntington Williams, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-12-1947, at 10 00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1947 to 6-12-1947 and that I last saw him alive on 6-11-1947

Immediate cause of death	Duration
Acute heart failure	1 hour
Due to generalized arterio-sclerosis & arterio-sclerotic heart disease	15 yrs
Due to + profound micro-cytic hypochromic anemia due to	6 yrs
Other Conditions hemorrhoids + rectal ulcers (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jack Cohen
Address 1804 Eutaw Pl. Date signed M. 6 D. 12/47

G52512

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G52512

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 950 Harlem Ave
(c) Hospital or institution: 16+1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Md (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HENRIETTA CATHERINE STEWART

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/14/1859

8. AGE: Years	Months	Days	If less than one day
87	6	17	2 3 hr. min.

9. Birthplace Balto, Md (Town, county, and state)
10. Usual Occupation Cook
11. Industry or business

FATHER
12. Name John Stewart
13. Birthplace Md

MOTHER
14. Maiden Name Mary
15. Birthplace Md

16 (a) Informant Florence Jackson (Niece)
(b) Address 950 Harlem Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/17/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N. Carrollton Ave

19 JUN 12 1947 (Registrar's signature) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/7/47 19 , at 6:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-6-1947 to 6-7-1947 and that I last saw h[illegible] alive on 6-7-1947.

Immediate cause of death: Myocarditis — Duration: 1 day

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr. G. A. Saunders M. D.
Address 1129 Mc Sturgis Date signed 6-14-47

G52513

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G52513 Registered No. 937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edwood & Greene Sts.
(c) Hospital or institution: University Hosp. 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3326 Fairfield Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stallings, Frank

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M. | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Married.

6 (b) Name of husband or wife Ida
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years 56 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER 12. Name Ralph Stallings
13. Birthplace N. C.

MOTHER 14. Maiden Name Priscilla ?
15. Birthplace Va

16 (a) Informant Cora Stallings
(b) Address 3326 Fairfield Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) June (day) 12 (year) 1947

(c) Cemetery or crematory Mt Calvary Cemetery
Location Balto Co, Md

18 (a) Funeral director Robt E Williams
(b) Address 1515 Mt Edward St

19 (a) Date received JUN 12 1947 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 1947, at 8:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/8 1947 to 19..., and that I last saw him alive on 6/8 1947.

Immediate cause of death Respiratory failure. — Duration

Due to cerebral hemorrhage. —

Due to hypertensive cardio-vascular disease. —

Other Conditions. —

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. W. Ligerton
Address University Hosp. Date signed 6/8/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52514

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

G52514 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 260 N. Bruce St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 260 N Bruce St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Stella Beard

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-12-3915

4 Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Robert Beard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sep. 23 1900

8. AGE: Years 46 | Months 8 | Days 19 | If less than one day hr. min.

9. Birthplace Eastern Md (Town, county, and state)

10. Usual Occupation Maid

11. Industry or business

FATHER 12. Name Samuel Skinner

13. Birthplace Easton Md

MOTHER 14. Maiden Name Margaret Fennell

15. Birthplace Easton Md

16 (a) Informant Ella Skinner

(b) Address Vienna Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 16, 1947 (month) (day) (year)

(c) Cemetery or crematory Mount Olivet

Location Baltimore City

18 (a) Funeral director Joseph A. Stanley

(b) Address 66 W Baltimore St

JUN 12 1947 (Date received by registrar) (b) Huntington Williamsburg Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1947 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/6 1947 to 6/11 1947 and that I last saw h[illegible] alive on 6/10/1947

Immediate cause of death Acute Cardiac Failure — Duration

Due to Chronic Endocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. F. Woodall D.

Address 601 Carroll Bldg Date signed 6/10/47

MYERS

G52515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

Registered No. G52515

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Baltimore City
(b) Street address 1318 McCulloh St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 H
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1318 McCulloh St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Myers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	Col	Widowed

6 (b) Name of husband or wife William Myers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/9/89

8. AGE: Years	Months	Days	If less than one day
58	5	2	hr. min.

9. Birthplace Baltimore, City
(Town, county, and state)

10. Usual Occupation -
11. Industry or business -

FATHER
12. Name Thackery Boynton
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Bessie Boynton
15. Birthplace Baltimore City

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/14/47 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Auburn
Location Mt Olivet

18 (a) Funeral director Thompson-Alexander
(b) Address 1400 McCulloh St

19 (a) JUN 12 1947 (Date received by registrar) Huntington Robinson, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1947, at 3P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1947 to June 11 1947 and that I last saw h alive on June 10 1947.

Immediate cause of death

	Duration
Acute Congestive Failure	6
Due to	2 M
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. J. Hall M.D.
Address 1515 Eutaw Pl Date signed 6/11/47

VS 150

G52516 — ELEANOR

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

96 ✓ Registered G52516

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2014 W Saratoga (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Eleanor R Hartman

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-14-9664

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife William H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 8, 1907

8. AGE: Years	Months	Days	If less than one day
40	2	2	hr. min.

9. Birthplace Balto md (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name John W Read
13. Birthplace md

MOTHER
14. Maiden Name Fannie Norwood
15. Birthplace md

16 (a) Informant Wm H Hartman
(b) Address 2014 W. Saratoga St Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-13-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore md

18 (a) Funeral director Frederick A Cole
(b) Address 208 W Lombard St Balto

19 (a) [illegible] (b) [illegible]

JUN 12 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 June 1947, at 8:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 29 MAY 1947 to 10 June 1947, and that I last saw h.E.R. alive on 10 June 1947

Immediate cause of death: Massive Cerebral Hemorrhage — Duration

Due to: Rupture Aneurysm of internal Carotid

Due to: H. C. V. D

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R E Bauer M. D.
Address Univ. Hosp Date signed 10 June 47

X

Garrett

052517

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131 B

Registered No. 052517

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1005 Brantley Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1005 Brantley Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lloyd Henry Garrett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Laura D.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 8, 1865

8. AGE: Years 82 | Months 5 | Days 1 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county and state)

10. Usual Occupation Custodian

11. Industry or business

FATHER 12. Name Richard S. Garrett

13. Birthplace Anne Arundel Co. Md.

MOTHER 14. Maiden Name Anna Maria ?

15. Birthplace Carroll Co. Md.

16 (a) Informant Mrs. Laura D. Garrett

(b) Address 1005 Brantley Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 13, 1947 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore, Md.

18 (a) Funeral director Mrs. George A. Ballard

(b) Address 1631 Druid Hill Ave

19 (a) (Date received by registrar) JUN 12 1947 Functioning for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9, 1947, at 7:22 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 30 1947 to June 9 1947 and that I last saw him alive on June 6 1947.

Immediate cause of death: Pulmonary Edema — Duration

Due to: Arteriosclerotic Cardiovascular Chronic Nephritis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. H. Howell, M.D.

Address 601 N. Carrollton Ave. Date signed 6/11/47

V S 150

G52518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G52518

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2135 N. Calvert St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2135 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Lucinda B. Galloway

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife James N.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1877

8. AGE: Years 69 | Months 9 | Days 29 | If less than one day hr. min.

9. Birthplace St. Mary's Co. Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George Bennett
13. Birthplace St. Mary's Co. Md

MOTHER
14. Maiden Name Fannie ? ?
15. Birthplace St. Mary's Co. Md

16 (a) Informant James N. Galloway
(b) Address 2135 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 13, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Geo. A. Hallowell
(b) Address 1631 Druid Hill Ave.

19 (a) Date received JUN 12 1947 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 1947 at 10:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 19XX to June 9 1947 and that I last saw h-r alive on June 3 1947.

Immediate cause of death	Duration
Chronic Valvular Heart Disease	3 yrs
Due to Cerebral Hemorrhage	6 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. Thomas Fay M.D.
Address 1928 Penna Ave Date signed 6/11/47

V S 150

G52519

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G52519

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 18 N Chapel, St.
(c) Hospital or institution: 6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 18 N. Chapel
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPHINE GUMMER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife John Gummer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 23, 1875

8. AGE: Years	Months	Days	If less than one day
72	2	16	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Adam Kuhn
13. Birthplace Germany

MOTHER
14. Maiden Name Josephine (?)
15. Birthplace

16 (a) Informant Josephine Kisling
(b) Address 34 N. Ellwood, Ave

17 (a) Burial (b) Date thereof 6 13 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director L. Tilly & Zeller Inc.
(b) Address 403 S Wolfe, St.

19 JUN 12 1947 (b) Huntington Nottingham
(Date rec'd by registrar) Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 1947, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 21 1946 to June 9 1947 and that I last saw h[illegible] alive on June 1947

Immediate cause of death Cerebral Hemorrhage

Duration 1 day

Due to

Due to

Other Conditions Coronary Thrombosis 4975

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jno. R. Johnson M. D.
Address 403 Med Arts Bldg Date signed 6-15-47

G52520

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1579

Registered No. G52520

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No. Route #1
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Landfair

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4 Sex: Male | 5 Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 4-23-47

8. AGE: Years | Months | Days 1 6 | If less than one day — hr. — min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Wendell Landfair

13. Birthplace Indiana Co. PA.

MOTHER 14. Maiden Name Mabel Weatherbaugh

15. Birthplace Mt. Pleasant, PA.

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June-14-1947 (month) (day) (year)

(c) Cemetery or crematory Pinion Cemetery
Location Silver Run, Md.

18 (a) Funeral director G. W. Little & Son

(b) Address Westminster, Md. Pa Ry Pd Huntington Williamsport, Md

19 (a) JUN 12 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 11th 1947 at 8:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from JUNE 3rd 1947 to JUNE 10th 1947. and that I last saw him alive on JUNE 10th 1947

Immediate cause of death	Duration
RESPIRATORY FAILURE	
Due to ASPIRATED MUCUS IN ASSOCIATION WITH	
Due to CONGENITAL VASCULAR ANOMALY - CONSTRICTING	
Other Conditions TRACHEA & ESOPHAGUS	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: CORROBORATING ABOVE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. A. Spencer M.D.

Address Johns Hopkins Hosp. Date signed 6/16/47

Harriett Lane Home

VS 150

G52521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G52521

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 4-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 613 E. Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alfred Hill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 55 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Hosp. Records Mercy Hosp.
(b) Address Calvert & Chase Sts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/13/47 (month) (day) (year)
(c) Cemetery or crematory National Cemetery
Location Frederick Road

18 (a) Funeral director Joseph Inman Inc.
(b) Address 2016 Pennsylvania Ave

19 JUN 12 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 June 1947, at 2 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cardiac Disease
over
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer Jr. M.D. Medical Examiner.
Date signed 9 June 1947

VS 181

G52522 ✓ G52522

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N. Calhoun
(c) Hospital or institution: Franklin Square Hosp. 9-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1005 Andover Rd. (If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country Italian

3 (a) FULL NAME Frances Rizzo

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	White	

6 (b) Name of husband or wife Gaetano Rizzo
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 18 1878

8. AGE: Years	Months	Days	If less than one day
69	4	23?	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Provenzano
13. Birthplace Italy

MOTHER
14. Maiden Name? Antoinette
15. Birthplace Italy

16 (a) Informant Phillis Fava
(b) Address 1005 Andover Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/14/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Joseph Fanara Inc
(b) Address 1 Fremont Ave

JUN 12 1947 (Date rec'd by registrar)

(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1947, at 12¹⁰ P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 11 1947 to June 11 1947, and that I last saw him alive on June 11 1947.

Immediate cause of death	Duration
Circulatory failure	?
Due to Acute myocardial infarct (?)	?
Due to	
Other Conditions Diabetes Mellitus (Includes pregnancy within 3 months of death)	8 yrs.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 7 Fremont Ave Date signed 6/11/47

VS 150

94a

G52523

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 195E

G52523 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 25
(c) Hospital or institution University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 915 Herndon Court (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Earl Triplett (Triplett)

3 (b) If veteran, name war

3 (c) Social Security Account No. 235-16-1501

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/12 1947, at 4:57 A M

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Emma Jane Triplett

6 (c) If alive, give age 31 6 years

7. Birth date of deceased (mo., day, yr.) 6-(1915)

8. AGE: Years	Months	Days	If less than one day
31	6	16	hr. min.

9. Birthplace Anthony W. Va. (Town, county, and state)

10. Usual Occupation Rigger

11. Industry or business Md Dry Docks

FATHER
12. Name Elmer Triplett
13. Birthplace W. Va

MOTHER
14. Maiden Name Bertha Payton
15. Birthplace W. Va

16 (a) Informant Mrs Emma Jane Triplett
(b) Address 915 Herndon Court - 25 zone

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 15-47 (month) (day) (year)
(c) Cemetery or crematory Sharp Cemetery
Location Marlinton W. Va.

18 (a) Funeral director Milton Schilling
(b) Address 3914 Hamburg St. - 25 -

JUN 12 1947 (Date rec'd by registrar) (b) Registrar

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Crushed Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 25/6

(a) Date of injury 6/11/47 at 9:20 P. M.
(b) Where did injury occur? Md. Drydock, Fairfield
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Struck by a sheet of steel

23. Signature [signature] M.D. Medical Examiner.
Date signed 6/12/47

VS 191

G52524 BALTIMORE CITY HEALTH DEPARTMENT X ✓ G52524
Registered No.

CERTIFICATE OF DEATH 136

PLEASE WRITE PLAINLY, WITH UNPADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Caroline
(c) City or town Preston
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rt #1 - Box 7
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Francis Friend

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9 - 1945

8. AGE: Years 1 | Months 20 | Days | If less than one day ___ hr. ___ min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James Friend
13. Birthplace N. J.

MOTHER 14. Maiden Name Annie Green
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof June 12/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Preston Md

18 (a) Funeral director Byron Perry
(b) Address Preston, Md.

(a) Date received by registrar JUN 13 1947 (b) Livingston Williamson, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-10-1947 at 4 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-24-1947 to 6-10-1947.
and that I last saw him alive on 6-10-1947.

	Duration
Immediate cause of death: Tuberculous meningitis	2 mos.
Due to: Miliary tuberculosis	2 mos.
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lawrence E. Greaney, M.D.
Address Johns Hopkins Hosp. Date signed 6/12/47

X

52525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G52525 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4120. Fayette St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 412 W. Fayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John McNulty

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Male	White	Widowed

6 (b) Name of ~~husband or~~ wife Maud McNulty
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) About 1872

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace Ireland
(Town, county, and state)
10. Usual Occupation Retired Police Officer
11. Industry or business Spring Grove Hospital

FATHER
12. Name Terrance McNulty
13. Birthplace Ireland

MOTHER
14. Maiden Name Jane Gafney
15. Birthplace Ireland

16 (a) Informant Matthew F. Martin
(b) Address Bloomsbury Ave. Catonsville

17 (a) Burial (b) Date thereof 6/14/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

JUN 13 1947 (b) Huntington Williams, M.D.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 June 1947, at 5:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammerer, Jr. M.D.
Medical Examiner.
Date signed 11 June 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G52526

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93c

Registered No. G56526

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1667 Darley Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1667 Darley Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William F. Calary

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-12-5867-A

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Ida J. Calary
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Feb. 10, 1870

8. AGE: Years	Months	Days	If less than one day
77	4	1	hr. min.

9. Birthplace Harford County, Md.
(Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Peter Calary
13. Birthplace Harford County, Md.

MOTHER
14. Maiden Name Edith Barber
15. Birthplace Harford County, Md.

16 (a) Informant Mrs. Ida J. Calary
(b) Address 1667 Darley ave

17 (a) Burial (b) Date thereof 6/14/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Howard N. Blight Jr.
(b) Address 6009 Harford Road

19 JUN 13 1947 by (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/11/47 19 , at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1947 to 6/11 1947 and that I last saw h[illegible] alive on 6/11 19 47

Immediate cause of death Thyroid Malignancy Metastasis

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Taylor Eakley M.D.
Address 5703 Harford Rd Signed 6/12/47

VS 150

G52527

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

Registered No. G52527

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4301 Valley View ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4301 Valley View ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alphaeus F. Williams

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-18-8642

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	widowed

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 17. 1869

8. AGE: Years	Months	Days	If less than one day
77	6	24?3	hr. min.

9. Birthplace Springfield County, Pa
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Jesse Williams
13. Birthplace Penna

MOTHER
14. Maiden Name Gillin
15. Birthplace Penna

16 (a) Informant Mrs. Bertha Ketchum
(b) Address 4301 Valley View ave

17 (a) Burial (b) Date thereof 6/13/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Frederick Road

18 (a) Funeral director Howard N. Blight Jr.
(b) Address 4914 Belair Road

19. JUN 13 1947 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1947, at 2a. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 23 1947 to June 9 1947, and that I last saw him alive on June 9 1947.

Immediate cause of death	Duration
Cancer of Oesophagus	1½ yr
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation April 23 1947
Major findings of operation: Inoperable Ca metastasis to liver
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R Walter Graham Jr M.D.
Address 1014 St Paul St Date signed 6/16/47

VS 150

X

G52528

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G52528

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 402 S. Regester Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 402 S. Regester Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME TINA (TENY) PLUM

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Andrew
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25, 1878

8. AGE: Years	Months	Days	If less than one day
69	2	15	hr. min.

9. Birthplace Radomysl, Poland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Walenty Pencek
13. Birthplace Radomysl, Poland

MOTHER
14. Maiden Name Maryanna ?
15. Birthplace Radomysl, Poland

16 (a) Informant Miss Thelma Plum
(b) Address 402 S. Regester Street

17 (a) Burial (b) Date thereof 6/14/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Road

18 (a) Funeral director M. J. Sadowski & Sons
(b) Address 1808 Eastern Avenue

19 (a) JUN 13 1947 Huntington Williams, M.D.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1947 at 3:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1947 to June 10 1947 and that I last saw h[illegible] alive on June 10 1947.

Immediate cause of death	Duration
Chronic Myocarditis	
Due to Arteriosclerotic Cardiovascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward B. Wolfe, M.D.
Address 133 Stockton Date signed 6/13/47

X

C52529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Register No. C52529

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4661 Pimlico Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4661 Pimlico Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Levin

3 (b) If veteran, name war

3 (c) Social Security Account No. 211-09-0369

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years	Months	Days	If less than one day
59			hr. min.

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation
11. Industry or business Bricklayer

FATHER
12. Name Israel Louis Levin
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah Rifka
15. Birthplace Russia

16 (a) Informant Mr Hyman M Levin
(b) Address 4661 Pimlico Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 13, 1947 (month) (day) (year)
(c) Cemetery or crematory Hebrew Washington Road
Location Washington Blvd

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (Filed) JUN 13 1947 Huntington Williamsport

MEDICAL CERTIFICATION 8.30

20. DATE OF DEATH June 12 1947, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1947 to June 12 1947 and that I last saw h[illegible] alive on June 12 1947

Immediate cause of death Cancer of pancreas — Duration 13 mon.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation May 17, 1946
Major findings of operations: Cancer head of pancreas
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Milton E Lowman M. D.
Address 4843 Park Heights Ave. Date signed 6/13/47

VS 150

G52530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G52530

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3207 Tyndale ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3207 Tyndale ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Margaret Kirchner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband or wife Richard C. Kirchner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27-1884

8. AGE: Years	Months	Days	If less than one day
62	10	15	hr. min.

9. Birthplace Brooklyn N.Y.
(Town, county and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER
12. Name Fred. Imig
13. Birthplace Germany

MOTHER
14. Maiden Name Emma Fleisher
15. Birthplace New York City

16 (a) Informant Richard C. Kirchner
(b) Address 3207 Tyndale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 14-1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Memorial Park
Location Baltimore Md.

18 (a) Funeral director Harold Cook Sylar
(b) Address 1600 W. North Ave

19 JUN 13 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 - 1947 at 2-50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 19 1942 to June 11 1947.
And that I last saw her alive on June 11 1947.

Immediate cause of death Cachexia, Metastatic Secondary Carcinoma — Duration 1 year

Due to Carcinoma of Left Breast

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Albert Rosenfield
Address 2015 E North Ave Date signed 6-12-47
M. D.

Dr. Von Schulz
652531 Edmondson Ave
6 to 8

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46E

Registered No. G52531

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2152 Druid Park Drive.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2152 Druid Park Drive. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Dorothea Menkens.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Henry H. Menkens.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 30, 1877

8. AGE: Years	Months	Days	If less than one day
69	5	12	hr. min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name John G. Fangmyer.
13. Birthplace Md.

MOTHER
14. Maiden Name Mary H. Stein.
15. Birthplace Md.

16 (a) Informant Mrs. John G. Gephardt, Sr.
(b) Address 2152 Druid Park Drive.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 14/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park.
Location Frederick Road.

18 (a) Funeral director Chenoweth & Donovan.
(b) Address 3615 17 Chestnut Ave.

19 (a) (Undertaker or other) (b) Huntington Williams, M.D. (Registrar)

JUN 13 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11, 1947, at 9.21 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1946 to June 11 1947, and that I last saw h.i.m. alive on June 11 1947.

Immediate cause of death: Carcinoma of sigmoid — Duration ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. P. Von Schulz, M.D.
Address 4818 Edmondson Ave. Date signed 6/12/47.

The G52532

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. G52532

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address. Green Spring Ave
(c) Hospital or institution: Levindale
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 28 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2622 Springdale Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA POLLACK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Benj [redacted]

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 72 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Siegel Pollack
13. Birthplace Russia

MOTHER
14. Maiden Name Moza -
15. Birthplace Russia

16 (a) Informant Isadore Pollack
(b) Address 2208 E. Balto. St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-13-47 (month) (day) (year)

(c) Cemetery or crematory Druid Hill Park Hamilton ave
Location Phila. Pike

18 (a) Funeral director Jack Levin Inc

(b) Address 1479 E. Balto. St

19 (a) Filed by [illegible] (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-12 1947 at 10:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-11 1947 to 6-12 1947 and that I last saw h[illegible] alive on 6-12 1947

Immediate cause of death: Carcinoma of ovary — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Irving Nagel

Address Levindale Home Date signed 6-12-47

X

G52533

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G52533

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 849 No Gay St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10'
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 849 No Gay St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name the country

3 (a) FULL NAME Joseph Stolnack

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Pauline

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 61 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Markle
13. Birthplace Russia

MOTHER
14. Maiden Name Hannah
15. Birthplace Russia

16 (a) Informant Eli Berman
(b) Address 849 N. Gay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-13-47 (month) (day) (year)
(c) Cemetery or crematory Helen Young Mem
Location Windsor Mill Rd.

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balt St

19 (a) JUN 13 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-13-47 19 at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1937 to 6/13 1947 and that I last saw him alive on 6/13, 1947.

Immediate cause of death: Arteriosclerotic Cardiovascular Disease — Duration: Few years
Due to
Due to
Other Conditions: Coronary Thrombosis — 1½ hours
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. A. Berman
Address 110 S. Calvert St Date signed 6/13/47 D.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G52534 CM. 111539 X 157E

Registered No. G52534

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern AVE •
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 55 Hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 14 14Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
Street No. 306 Wheeler CT. Z 22
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fogg, Carolyn Cheryle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27 -1947

8. AGE: Years	Months	Days	If less than one day
0	0	14	hr. min.

9. Birthplace MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Fogg
13. Birthplace VA.

MOTHER
14. Maiden Name Mildred Curtis
15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-14-47 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Park
Location

18 (a) Funeral director Payzer Sanders
(b) Address 1412 E. Preston St

19 JUN 13 1947 (b) Huntington Williams, Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11- 1947, at 9.00P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 11.-1947 to June 11-1947, and that I last saw h. alive on June 11 - 1947

Immediate cause of death	Duration
Congenital heart disease	Life
Due to: T. V. septal defect. Descending aorta arising from pulm. artery.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wilson E. Hughes M. D.

Address Balto City Hosp Date signed June 12 49

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52535

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1313

Registered No. G52535

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Lyndenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 29 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 215 E 23rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jones, Robert Henry William

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct. 13, 1918
8. AGE: Years 29 Months 7 Days 29 If less than one day hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name William Jones
13. Birthplace Virginia

MOTHER
14. Maiden Name Sarah Epps
15. Birthplace Virginia

16 (a) Informant Relative
(b) Address 215 E 23rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-14-47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A. A. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) JUN 13 1947 Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1947 at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1947 to June 11 1947, and that I last saw him alive on June 11 1947

Immediate cause of death	Duration
Tuberculous meningitis	
Due to Miliary tuberculosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas Robinson M. D.
Address Lyndenham Hosp. Date signed 6/12/47

652536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

Registered No. 652536

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 718 W. Barre St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 718 W. Barre St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Emma L. Emmert

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late Christian Emmert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 31st 1861

8. AGE: Years 86 | Months 4 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation House work

11. Industry or business at home

FATHER
12. Name August Westling
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Kroman
15. Birthplace Germany

16 (a) Informant Mrs Norman R Emmert
(b) Address 2009 Penrose Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/14/47 (month) (day) (year)
(c) Cemetery or crematory London Park Cem
Location 3901 Frederick Rd

18 (a) Funeral director John J. Gowan & Son
(b) Address 901-03 Hollins St.

19 (a) JUN 13 1947 (Registrar's Office) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12th 1947 at 7.30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 31 1947 to June 10 1947 that I last saw him alive on June 10, 1947

Immediate cause of death	Duration
Arteriosclerotic cardio-vascular disease.	10 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ira Jeppinelli M.D.
Address 71 Medical Arts Bldg Date signed 6/13/47

VS 150

G52537

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No. G52537

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2510 Greenmount Ave
(c) Hospital or institution: Southern Home & Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2510 Greenmount Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie E. Smith

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 2, 1856

8. AGE: Years	Months	Days	If less than one day
91	5	9	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Samuel H. Smith
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Mary Eaton
15. Birthplace Balto. Md

16 (a) Informant Mrs. Leslie W. Smith
(b) Address 903 E. 37th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/14/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Rve, Balto. Md

18 (a) Funeral director John O. Mitchell Funeral Home
(b) Address 1900 Eutaw Place

19 JUN 13 1947 (b) Huntington W. Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-8-47 19 to 6-11-47 19, and that I last saw her alive on 6-10-47 19

Immediate cause of death	Duration
Acute dilatation of heart	2 hrs
Due to	
Due to	
Other Conditions age	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hyslop C. Blade M.D.
Address 422 Med. Arts Bldg. Date signed 6-13-47

VS 150

G52538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1313

G52538 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The digest are is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3 W. Heath ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3 W. Heath ST (If rural give location)
(e) Citizen of foreign country? X (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Katherine Kopp.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Caspar Joseph Kopp.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 18-1873

8. AGE: Years 74 | Months 2 | Days 22 | If less than one day hr. min.

9. Birthplace Balto. - Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Ernest Wm Fischbach

13. Birthplace Germany

MOTHER 14. Maiden Name Martha Jacobs

15. Birthplace Germany

16 (a) Informant Caspar J. Kopp

(b) Address 3 W. Heath St Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 13 1947 (month) (day) (year)

(c) Cemetery or crematory Meadowridge

Location Washington Road

18 (a) Funeral director McCully Funeral Home

(b) Address 432 E. Foot ave

19 June 13 1947 (b) Huntington Millionaire, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10th 1947, at 2.25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 18 1947 to Jun 10 1947 and that I last saw h alive on June 10 1947

Immediate cause of death Acute Dilatation of Heart — Duration 3 days

Due to Chronic Nephritis — Duration 3 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. F. Sumptred M. D.

Address 1644 Hanover Date signed 6/10/47

G52539

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 23B

G52539 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1108 Brewer
(c) Hospital or institution:
17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 18 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1108 Brewer Pl
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Parker

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	B	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years	Months	Days	If less than one day
50			hr. / min.

9. Birthplace South Carolina
(Town, county, and state)

10. Usual Occupation Home

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Rodda?
15. Birthplace SC

16 (a) Informant Ruth Gresham
(b) Address 1108 Brewer

17 (a) Burial (b) Date thereof 6-16-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem
Location A. G. County Md

18 (a) Funeral director C. Hollyday
(b) Address 918 Druid Hill Ave

19 (a) JUN 13 1947 Registrar's Office Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/12/47 19 at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1947 to June 12 1947
and that I last saw h— alive on April 1947

Immediate cause of death	Duration
Cystic Kidney	
Pyelonephritis	
Following Hysterectomy	2 Months
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Lee Ellis M. D.
Address 9x / Mt Royal Ave Date signed 6-16-47

VS 150

X

G52510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

Registered No. G52510

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 DIVISION ST
(c) Hospital or institution: PROVIDENT
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11d. 16
(e) Length of stay in Baltimore (yrs., mos., or days) 15yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County BALTIMORE
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1514 LAFAYETTE AVE
(If rural give location)
(e) Citizen of foreign country? N.C. (Yes or No)
If yes, name country

3 (a) FULL NAME VIRGIE COOPER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	NEGRO	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 30 1906

8. AGE: Years	Months	Days	If less than one day
41	0	8 10	hr. min.

9. Birthplace ST. MARYS CO. (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant MRS. CATHERINE HAWKINS
(b) Address 1517 EDMONDSON AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 6-12-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Forest County

18 (a) Funeral director ADOLPHUS HALSTEAD
(b) Address 918 DRUID HILL AVE.

19 (a) JUN 13 1947 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 9 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from JUNE 9 1947, to JUNE 9 1947, and that I last saw her alive on JUNE 9 1947.

Immediate cause of death	Duration
INTESTINAL OBSTRUCTION	
Due to INTESTINAL ADHESIONS	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature I. B. Higgins, Resident
Address Provident Hospital Date signed 6/7/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

G52541 **CERTIFICATE OF DEATH** 1937 Registered No. G52541

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1504 Druid Hill Avenue (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Frances Gant

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-05-2664

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Mar

6 (b) Name of husband or wife: Hazel

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 12/29/1898

8. AGE: Years 48 | Months 5 M | Days 12 | If less than one day ..... hr. ..... min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Longshoreman

11. Industry or business

FATHER 12. Name Wes. Gant

13. Birthplace Va

MOTHER 14. Maiden Name —

15. Birthplace —

16 (a) Informant Hazel Gant

(b) Address 2504 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal), (b) Date thereof 6/13/47 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Md

18 (a) Funeral director Wes. A. Kelson

(b) Address 1303 Pennsylvania Ave

19 (a) JUN 13 1947 (Registered by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10, 1947, at 1:05 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Spontaneous Subarachnoid Hemorrhage

Due to Hypertensive cardiovascular disease

Other Conditions —

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury..... at..... M.

(b) Where did injury occur?.....

(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....

(d) Means of injury.....

23. Signature Carl V. Voss M.D. (Medical Examiner)

Date signed 6-11-47

VS 151

X

G52542

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G52542

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 514 Old Orchard Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 514 Old Orchard Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Grace Forrester

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: late J. Frank Forrester
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 23, 1871

8. AGE: Years 76 | Months 2 | Days 19 | If less than one day ... hr. ... min.

9. Birthplace W. Va.
(Town, county, and state)

10. Usual Occupation H. W.

11. Industry or business

FATHER
12. Name Ebenezer W. Lippencott
13. Birthplace N. Y.

MOTHER
14. Maiden Name Annabel Weir
15. Birthplace Loudoun

16 (a) Informant J. Townsend Parks
(b) Address 514 Old Orchard Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/14/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location 801 Frederick Rd.

18 (a) Funeral director Harry H. Nitzke
(b) Address 4101 Edmondson Ave

19 (a) JUN 13 1947 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/12/47 19 at 5.30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 27 1947, to June 12 1947, that I last saw her alive on June 11 1947.

Immediate cause of death: Carcinoma, ascending Colon — Duration: about 1½ years

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. F. Gaver M. D.
Address Baltimore, Md. Date signed 6/13/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52513 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G52513

In. 109176 — **CERTIFICATE OF DEATH** — 109176 — 186a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos. ~~or~~ days) 2- 27
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6802 Linden Ave, Balto. County
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Emma Keiningham

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: William W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10th. 1858

8. AGE: Years 88 | Months 10 | Days 2 | If less than one day hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name James Edwards
13. Birthplace Virginia

MOTHER
14. Maiden Name Rosie Mason
15. Birthplace Virginia

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/14/47 (month) (day) (year)
(c) Cemetery or crematory Harmony Grave
Location Harmony Grave Baptist Church Md

18 (a) Funeral director W. W. E. Dennis & Sons
(b) Address Eastern and Ponca Sts Baltimore, Md

19 (a) JUN 13 1947 (Registrar's Record) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12th 1947 at 7.10 A.M. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 15th 1947 to June 12 1947, and that I last saw h~~er~~ alive on June 12 1947.

Immediate cause of death: Coronary occlusion — Duration:
Due to Arteriosclerotic heart disease
Due to
Other Conditions: Hemiplegia arteriosclerosis; Intertrochanteric fracture right femur.
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 2/25/47 at ? M
(c) Where did injury occur? Baltimore (City or town) Baltimore (County) Md. (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? no
(e) Means of injury Fell down steps

23. Signature R. B. Gibbs
Address Baltimore City Hospitals Date signed 6/12/47

To be approved by Medical Examiner
S.B. Merrill MD

V S 150

G52544

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G52544

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 16 W Talbott St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 49 E Montgomery St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lama Virginia Taylor

3 (b) If veteran, name war: W
3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Elmer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5, 1866

8. AGE: Years 80 | Months 11 | Days 7 | If less than one day hr. min.

9. Birthplace Marion Station Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Thomas Dougherty
13. Birthplace Unknown

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Foster Taylor
(b) Address 2213 Edmondson Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/14/47 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie Md

18 (a) Funeral director Tilhon & Son
(b) Address 217 Fort Ave
(c) Huntington Williams, M.D. Registrar
(Date received by registrar) JUN 13 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1947, at 1 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1 1945 to 6-12 1947, and that I last saw h-- alive on 6-11 1947.

	Duration
Immediate cause of death: Chronic Myocardial Degeneration	2 yrs.
Due to: Cerebral Embolism	2 yrs.
Due to:	
Other Conditions: Carcinoma of stomach	1 yr.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. J. Sollod M. D.
Address 207 Fort Ave. Date signed 6-13-47

VS 150

927

G52545 G52545

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 304 Hilchester Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 304 Hilchester Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E Kelley.

3 (b) If veteran, name war W

3 (c) Social Security Account No. none

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Burlington Kelley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 10 1872

8. AGE: Years 74 | Months 10 | Days 1 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Henry Trieschmann
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Carroll D. Higgins
(b) Address 304 Hilchester Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/14/47 (month) (day) (year)
(c) Cemetery or crematory Woods Chapel
Location Carroll Co Md

18 (a) Funeral director Fallhoon Coffee
(b) Address 1217 E Fayette St

19 (a) [illegible] (b) Washington Williams, Mortician

JUN 13 1947

VS 153

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1947, at 8:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 11, 1947, to June 11, 1947, and that I last saw h[illegible] alive on June 11, 1947.

Immediate cause of death	Duration
acute Myocardial Failure	5 minutes
Due to Chronic Myocarditis	?
Due to ~	
Other Conditions ~	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ~
(b) Date of occurrence ~ at ~ M
(c) Where did injury occur? ~
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ~ While at work? ~
(Specify type of place)
(e) Means of injury

23. Signature Frank M. Ogden M. D.

Address 2701 N. Calvert St. Date signed June 12, 47

X

G52546

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G52546

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 West Lexington St.
(c) Hospital or institution:
Aged Women's & Aged Men's Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give county)
(d) Street No. 1400 W Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lily Tilyard Leber

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 5, 1868

8. AGE: Years 78 | Months 7 | Days 6 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Jacob H. Leber
13. Birthplace

MOTHER
14. Maiden Name Emma Lucy Tilyard
15. Birthplace

16 (a) Informant L. N. Read Supt.
(b) Address 1400 West Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/13/47 (month) (day) (year)
(c) Cemetery or crematory Dorsett Park
Location Woodlawn, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 N. Paul St.

19 (a) JUN 13 1947 (Date rec'd by registrar) Huntington Williams, Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11th 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/17/47 19 to 6/11/47 19, and that I last saw her alive on 6/10/47 19

Immediate cause of death	Duration
Acute coronary artery disease	1 day
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas B. Jarrett, M. D.
Address 11 E. Chase St., City Date signed 6/13/47

G52517

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G52517 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 214 Douglas Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 214 Douglas Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Neal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Mary Neal

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Aug 10-1880

8. AGE: Years 66 | Months 10 | Days 1 | If less than one day: hr. min.

9. Birthplace Georgia (Town, county, and state)

10. Usual Occupation Horseman

11. Industry or business

FATHER 12. Name Washington Neal

13. Birthplace Georgia

MOTHER 14. Maiden Name Mary Neal

15. Birthplace Georgia

16 (a) Informant Mary Neal

(b) Address 214 Douglas Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 15, 1947 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial Park

Location Arbutus Md

18 (a) Funeral director Elroy O. Wilson

(b) Address 1022 Beaty ave

19 (a) June 13 1947 registrar (b) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1947, at 12 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/2 1947, to 6/11 1947, and that I last saw h.. alive on 6/9 1947

Immediate cause of death: Tuberculosis of oesophagus + lung — Duration: 5 or 6 yrs.

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Rayner Browne M.D.

Address 1210 E. Madison St Date signed 6/12

Rayner Browne X

G52548

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G52548 Registered No. 166

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County
(c) City or town Arlington (If outside city or town limits, write RURAL, and give town)
(d) Street No. 5211 N. Washington Blvd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard William Sheehan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26, 1912

8. AGE: Years 34 | Months 5 | Days 18 17 | If less than one day ____hr. ____min.

9. Birthplace Essex Junction, Va. (Town, county, and state)

10. Usual Occupation Truck driver

11. Industry or business

FATHER
12. Name Thomas Edward Sheehan
13. Birthplace Troy, N.Y.

MOTHER
14. Maiden Name Elizabeth Perkins
15. Birthplace Burlington, Vt.

16 (a) Informant Ives Funeral Home
(b) Address Arlington, Va.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof June 13, 1947 (month) (day) (year)
(c) Cemetery or crematory Columbia Gardens
Location Arlington, Va.

18 (a) Funeral director Wm. J. Fickner & Sons
(b) Address North & Pa. Aves.

(a) (Date rec'd by registrar) (b) Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1947 at 7:25 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Bullet wound of liver, with massive abdominal hemorrhage.
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-12-47 at 7:00 A.M.? (Hour)
(b) Where did injury occur? Circus Grounds.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial Place While at work? no
(d) Means of injury Firearms

23. Signature George L. Merrill M.D. Medical Examiner.
Date signed 6-12-47

Huntington Williams, MD

X

G52519

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

G52519 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1701 Bolton St.
(c) Hospital or institution: ---------- 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ----------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 Bolton St.
(If rural give location)
(e) Citizen of foreign country? ---------- (Yes or No)
If yes, name country ----------

3 (a) FULL NAME Miss Katherine Lee Dolly

3 (b) If veteran, name war ----------
3 (c) Social Security Account No. ----------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife ----------
6 (c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) May 26, 1864

8. AGE: Years	Months	Days	If less than one day
83	---	16	--- hr. --- min.

9. Birthplace Montgomery Co., Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business ----------

FATHER
12. Name Adam B. Dolly
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary R. Tabert
15. Birthplace Prince George C. Md.

16 (a) Informant Mrs. T. Howard Embert
(b) Address 1701 Bolton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/14/47 (month) (day) (year)
(c) Cemetery ~~########~~ Loudon Park
Location Baltimore, Md.

18 (a) Funeral director H. H. Mears and Son
(b) Address 805 N. Calvert St.

19 [illegible] JUN 13 1947 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1947, at 4:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 18 1945 to June 14 1947, and that I last saw h~~e~~r alive on June 12 1947.

Immediate cause of death	Duration
Myocardial Insufficiency	5 days
Due to Cardio-Vascular nephritis duration	2 or 3 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Bowers and Son M.D.
Address 2200 Garrison Blvd Date signed 6-16-47

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X

G52550

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

Registered No. G52550

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2037 E. Federal St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 y 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2037 E. Federal St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Bauer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 24th 1875

8. AGE: Years 71 | Months 9 | Days 17 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name George Bauer
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Klitch
15. Birthplace Germany

16 (a) Informant Wm. H. Mitchell
(b) Address 2037 E. Federal St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/14/47 (month) (day) (year)
(c) Cemetery or crematory St. Matthews
Location Balto. Md.

18 (a) Funeral director E. J. Feeney & Son
(b) Address 1938 E. Lafayette Ave

19 (a) JUN 13 1947 (b) Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1947, to June 11 1947, and that I last saw h[er] alive on June 11 1947.

Immediate cause of death: Valvular Heart

Due to disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jacob Frahm M. D.

Address 1822 N. Wood St. Date signed 6/13/47

X

G52551

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 74a

Registered No. G52551

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Broadway
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla. (b) County Pinellas
(c) City or town St. Petersburg (If outside city or town limits, write RURAL and give town)
(d) Street No. 1033 Bay St. N.E. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Maxine Dibbell (Maxine Tilden Dibbell)

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Edgar B. Dibbell
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.): 4-18-98

8. AGE: Years 49. | Months 1 | Days 25 | If less than one day: hr. min.

9. Birthplace: Md. (Town, county, and state)

10. Usual Occupation: Home wife

11. Industry or business

FATHER
12. Name: Harry Tilden
13. Birthplace: Mass.

MOTHER
14. Maiden Name: Jenia Waldrop
15. Birthplace: Va

16 (a) Informant: Rhonda.
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or Removal) (b) Date thereof 6-14-47 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet
Location: Balto. Md.

18 (a) Funeral director: Sherwood Morgan Co.
(b) Address: 1018 W. York Ave.

19 (a) JUN 13 1947 (Date rec'd by registrar) (b) Registrar's signature: [illegible]

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MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1947 at 2:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 7 1947, to June 12 1947 and that I last saw her alive on June 12 1947.

Immediate cause of death	Duration
Acute Myelogenous	
Due to Leukemia	4 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Amy Knight M. D.
Address: J.H.H. Date signed June 12-47

C52552

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C52552

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 202 S Castle St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 202 S Castle St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frances Nowak

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-05-6268

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19, 1887

8. AGE: Years	Months	Days	If less than one day
60	3	22	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Lawrence Cyzinski
13. Birthplace Poland

MOTHER
14. Maiden Name Josephine ?
15. Birthplace Poland

16 (a) Informant Josephine Dobrzynkowski
(b) Address 312 S Castle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-17-47 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore Md

18 (a) Funeral director George A Weber
(b) Address 705 S Arlington Ave

19 JUN 13 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1947, at 1:00 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy + Inquiry thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Less death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 6-13-47

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correct age is especially important. Physicians: please write the

G52553

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 95B

Registered No. G52553

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. Hollyneck Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RUTH A. WATTS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Philip E. Watts

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 22, 1904

8. AGE: Years 43 | Months 1 | Days 19 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name J. Hardy Armstrong
13. Birthplace Balto.

MOTHER
14. Maiden Name Lydia Leaf
15. Birthplace Balto.

16 (a) Informant Mr. Philip E. Watts
(b) Address Hollyneck Rd., Essex

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/14/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (Date received) JUN 13 1947 Huntington Williams, M.D.

V S 190

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11, 1947 at 4:15a M

21. I certify that death occurred on the date above stated; that I attended deceased from November 1946 to June 11 1947
and that I last saw h.er alive on June 6 1947

	Duration
Immediate cause of death: Cerebral embolus	
Due to: Cerebral Softenation	10 mo.
Due to: Rheumatic Cardiac Disease	15 yr.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jos. Miegle M. D.
Address 3-B Mars Rd Date signed 6/14/47

Jos. Miegle
3-B. Mars Rd. X

G52554

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓94a

Registered No. G52554

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1411 N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur G. Clark

3 (b) If veteran, name war none

3 (c) Social Security Account No. 212-03-9345

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widow

6 (b) Name of husband or wife Lillian Clark
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 14, 1889

8. AGE: Years	Months	Days	If less than one day
58 57	4	27	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired Painter

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mr. Arthur B. Clark (4th Detachment)
(b) Address Fort Bragg, N. C.

17 (a) Burial (b) Date thereof 6/14/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Balto., Md.

JUN 13 1947

19 (a) (Date rec'd by registrar) (b) Huntington Hollins, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1947 at 12 65 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Jun death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to Generalized Arteriosclerosis

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D.
Medical Examiner.
Date signed 6-12-47

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X

Please write plainly in ink or typewrite. Spell out all words. Do not use abbreviations or symbols. Be careful and accurate in answering every question. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52555

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G52555

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Union Memorial Hosp. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2403 N. Calvert St
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Willie L. Willis

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Elizabeth Willis

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 9, 1898

8. AGE: Years 49 | Months 3 | Days 2 | If less than one day ..... hr. ..... min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation Quartermaster

11. Industry or business U. S. C.&G. Survey Co.

FATHER
12. Name William A. Willis
13. Birthplace N. C.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Betty Willis, wife
(b) Address 2403 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/14/47 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet Cem. Location Morehead Beaufort N.C.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19. JUN 13 1947 (Date received by Registrar) (b) Thurlow Weed Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1947, at ..... M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to ..... death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature [signature] M.D.
Medical Examiner.
Date signed 6-16-47

X

Form approved. Typewriter or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

52556

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. 52556

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 North Caroline ST.
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 33 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 111 S. COLLINGTON AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** JOHN KOSAKOSKI

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 1881

8. AGE: Years	Months	Days	If less than one day
66	-		hr. min.

9. Birthplace POLAND (Town, county, and state)

10. Usual Occupation LABORER

11. Industry or business

FATHER 12. Name —

13. Birthplace Poland

MOTHER 14. Maiden Name

15. Birthplace Poland

16 (a) Informant Theodore Penski

(b) Address 111 S. Collington ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-16-47 (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus

Location Balto. City

18 (a) Funeral director Wm. J. Fialkowski

(b) Address 2007 Eastern Ave

19 (Signature of registrar) JUN 13 1947 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 June 1947 to 13 June 1947 and that I last saw him alive on 13 June 1947

Immediate cause of death	Duration
CARDIO-Respiratory failure	
Due to Advanced carcinoma of stomach	
Due to	
Other Conditions Suddiophrenatic abscess	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Carcinoma of stomach

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard A. Young, M.D.

Address 1 S. Grayson Hwy. Date signed

VS 150

G52557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G52557 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1710 Hollins Street
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore-23 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1710 Hollins Street (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mary Hyschalk (Roman)

3 (b) If veteran, name war
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Michael
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1869 ?

8. AGE: Years 78 ? | Months 3 | Days | If less than one day hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Protyniak
13. Birthplace Unknown

MOTHER
14. Maiden Name Mary ?
15. Birthplace Unknown

16 (a) Informant Mrs. Anna Bodnar (Daughter)
(b) Address 1710 Hollins Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-16-47 (month) (day) (year)
(c) Cemetery or crematory St. Michaels Greek
Location Baltimore, County Md.

18 (a) Funeral director George A. Weber
(b) Address 705 S. Ann Street

19 (a) JUN 13 1947 (Date rec'd by registrar) (b) Registrar's signature

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12th 1947, at 11:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/10 1946 to 6/12 1947, and that I last saw h[illegible] alive on 6/5 1947.

	Duration
Immediate cause of death: Acute cardiac dilatation	1 day.
Due to: Carcinoma of the	2 yrs.
Due to: stomach	5 yrs.
Other Conditions: Chronic myocarditis	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed

G52558

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164E

Register's No. G52558

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2445 Lakeview ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lester M. Lowenthal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mildred W. Lowenthal

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch. 14, 1901

8. AGE: Years 46 | Months 2 | Days 29 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER
12. Name Jacob Lowenthal
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Minnie Rainoch
15. Birthplace Petersburg Va

16 (a) Informant Mrs. Mildred Lowenthal
(b) Address 2445 Lakeview Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/15/47 (month) (day) (year)
(c) Cemetery or crematory Balto. Hebrew
Location Balto. Md.

18 (a) Funeral director Harris Sondheim's Sons
(b) Address 902 Eutaw Place

19 (a) JUN 13 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/12 1947 at 9A M

21. I certify that I took charge of the remains described above, held an Autopsy Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Crushed skull.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 6-12-47 at 3 A. M.
(b) Where did injury occur? Lord Balto. Hotel Hanover & Balto. sts
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Jumped from window

23. Signature [signature] M.D. Medical Examiner

Date signed

VS 191

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52559

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G52559

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp 24
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3823 Fait Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HERMAN J. PLATT

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 18 - 1897

8. AGE: Years	Months	Days	If less than one day
50	2	24	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Henry Platt
13. Birthplace Balto

MOTHER
14. Maiden Name Barbara Schatz
15. Birthplace Balto

16 (a) Informant Mrs. Kuhn
(b) Address 3823 Fait Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-16-47 (month) (day) (year)
(c) Cemetery or crematory Laurel Hill Co
Location O'Donnell St Rd

18 (a) Funeral director John B. Connelly
(b) Address 416 Eastern Ave

19 (a) JUN 13 1947 (Date Rec'd by Reg.) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1947 at 12:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒; accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 6/12/47

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 151

File G52560

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G52560

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2520 Madison Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2520 Madison Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Otho A. Webb.

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-05-2311

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-5-1875

8. AGE: Years	Months	Days	If less than one day
71	11	6	hr. min.

9. Birthplace Harford County, Md.
(Town, county, and state)

10. Usual Occupation Public Waiter

11. Industry or business

FATHER
12. Name John Webb
13. Birthplace Unknown

MOTHER
14. Maiden Name Olivia Kell
15. Birthplace Harford County, Md.

16 (a) Informant John S. Henson
(b) Address New Cut Rd. Ellicott City Md

17 (a) Burial (b) Date thereof 6/14/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Western Star
Location Catonsville, Md.

18 (a) Funeral director Charles H. Alexander
(b) Address 1200 McCulloh Street

19 Date received by (b) JUN 13 1947 Registrar for Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1947, at 7.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1947, to June 11 1947, and that I last saw him alive on June 11 1947.

Immediate cause of death Congestive Heart Failure — Duration ?

Due to

Due to

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 2301 Madison Ave Date signed 6/12/47

VS 150

G52561

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5 1 C

G52561
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 91 days
(e) Length of stay in Baltimore (yrs., mos., or days) 91 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mich. (b) County
(c) City or town Traverse City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 428 Sixth St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME George Anthony Spaargaren

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Judith Moulton Spaargaren
6 (c) If alive, give age 26 years

7. Birth date of deceased (mo., day, yr.) July 8, 1916

8. AGE: Years	Months	Days	If less than one day
30	11	5	hr. min.

9. Birthplace Lyden, Holland
(Town, county, and state)
10. Usual Occupation Coast Guard Service
11. Industry or business

FATHER
12. Name Cornelius Spaargaren
13. Birthplace Holland

MOTHER
14. Maiden Name Nellie Knaap
15. Birthplace Holland

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 17 1947 (month) (day) (year)
(c) Cemetery or crematory
Location Traverse City Michigan

18 (a) Funeral director Roth C. A. M. Wilson
(b) Address Asst. Chief

JUN 13 1947 (Date filed by Registrar) Tomlinson Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1947, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 14 19__ to June 13 1947; that I last saw him alive on June 13 1947

Immediate cause of death (1) Embryonal carcinoma of right testis (resected) with lung, liver and retroperitoneal tonsal metastasis — Duration: UNKNOWN
(2) Pneumonia lobular, left lower lobe — Duration: 4 days

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon, M.D.
Address Clinical Director Date signed 6/13/47

VS 150

X

G52562

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G52562

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1418 Marshall St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1418 Marshall St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward J. Curley

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 16-1863

8. AGE: Years	Months	Days	If less than one day
83	6	26	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business Retired

FATHER
12. Name Thomas Curley
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Morgan
15. Birthplace Ireland

16 (a) Informant Mrs Annie Curley
(b) Address 1418 Marshall St.

17 (a) Burial (b) Date thereof 6-16-1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Greatstone Cemetery
Location Baltimore Md

18 (a) Funeral director Flynn & Fleming
(b) Address 1416 Light St.

19 (a) [illegible] 13 1947 [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1947 at 1:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1947 to 6-12 1947 and that I last saw [illegible] alive on 6-12 1947.

Immediate cause of death	Duration
Exhaustion	8 days
Due to Arteriosclerosis	5 yrs
Due to	Indefinite
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature P. E. L. Campbell M.D.
Address 644 Hamburg St. Date signed 6/13/47

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G52563

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G52563

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2601 Roslyn Ave.
(c) Hospital or institution:
convalescent home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3312 W. North Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Annie L. Reese

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 31, 1865

8. AGE: Years	Months	Days	If less than one day
82	4	12	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name John E. Reese
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Alice V. Gibbs
15. Birthplace Va.

16. (a) Informant Matthias F. Reese
(b) Address 3312 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/14/47 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location North & Greenmount Aves.

18 (a) Funeral director John D. Mitchell & Sons, Inc.
(b) Address 1600 Eutaw Place

19 (a) JUN 13 1947 (Date rec'd by registrar) Functioning for Nobleman, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12, 1947, at 9 P. M
21. I certify that death occurred on the date above stated; that I attended deceased from 6-11 1947, to 6-12 1947, and that I last saw her alive on 6-11 1947.

	Duration
Immediate cause of death: Cerebral Hemorrhage	2 days
Due to: arteriosclerosis	?
Hypertension	?
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature L. Harrell Pierce M. D.
Address Medical Arts Bldg. Date signed 6-13-47

VS 150

Over X

Dr. A. Scagnetti
1729 W. Lombard St.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. C52564

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 340 S. Stricker Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 340 S. Stricker Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: William H. Wiebking

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife: Bessie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 30, 1886

8. AGE: Years	Months	Days	If less than one day
60	7	12	hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Retired
11. Industry or business: Rest. & Tavern Owner

FATHER
12. Name: William Wiebking
13. Birthplace: Md.

MOTHER
14. Maiden Name: Mary Lotz
15. Birthplace: Md.

16 (a) Informant: Mrs. Anna Linker
(b) Address: 340 S. Stricker Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/14/47 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore, Maryland

18 (a) Funeral director: Leonard J. Ruck
(b) Address: 5305 Harford Road, 14

19 (a) JUN 13 1947 (Huntington Williams, M.D.) Address

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 3 1947 to June 11 1947 and that I last saw him alive on June 11 1947.

Immediate cause of death: Cardiac Failure — Duration
Due to: Chronic Myocarditis
Due to:
Other Conditions: Bronchial Asthma, Cardiac Origin
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Albert Scagnetti M. D.
Address 1729 W Lombard St Date signed 6/13/47

VS 150

X

G52565

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G52565 Registered No. 61

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Havre de Grace
(If outside city or town limits, write RURAL and give town)
(d) Street No. 200 N. Union Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** George Burlingame

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Amanda

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-5-73.

8. AGE: Years	Months	Days	If less than one day
74	-	8	hr. min.

9. Birthplace Mass
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Geo. Albert Burlingame

13. Birthplace Mass.

MOTHER 14. Maiden Name Eliz. Ann Hemingway

15. Birthplace Mass

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Cremation (b) Date thereof June 16, 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Balto. Md.

18 (a) Funeral director R. McGuigan Mitchell

(b) Address Havre de Grace, Md.

19 (a) (b)
(Date received by registrar) Registrar

JUN 13 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1947 at 8:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 7 1947 to June 18 1947 and that I last saw him alive on June 13 1947.

Immediate cause of death	Duration
Acute Myocardial Infarction	
Due to Coronary Occlusion	
Due to Pulmon. Infarction	
Diabetes mellitus	
Other Condition Renal failure	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. M. Knight M. D.

Address Date signed

X

G52566

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G52566 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 207 Hawthorne Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 207 Hawthorne Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Ridgely Dorsey

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	widowed

6 (b) Name of husband or wife Richard Dorsey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 26 1870

8. AGE: Years	Months	Days	If less than one day
76	5	17	hr. min.

9. Birthplace Sykesville Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John T. Ridgely
13. Birthplace Md

MOTHER
14. Maiden Name Sarah A. Ijams
15. Birthplace Md

16 (a) Informant Richard Dorsey Jr.
(b) Address 106 N University Pkwy

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 14/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Kenny W. Jenkins Co. Inc.
(b) Address McCulloh & Richard Sts

19 (a) JUN 13 1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 12 1947, at 7 10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from NOV 1946 to JUNE 1947.
and that I last saw HER alive on JUNE 12 1947

Immediate cause of death	Duration
CARCINOMA OF COLON	10? MOS
WITH METASTASES TO	
Due to OMENTUM & LIVER	
Due to	
ARTERIOSCLEROSIS	20 YRS
Other Conditions ESSENTIAL HYPERTENSION - UREMIA	INDEFINITE

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Ralph J. Wells Jr. M.D.
Address 18 E Eager St Balto Date signed JUNE 12 47 M. D.

VS 150

G52567 Hellmann ✓ G52567

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 12

Registered No.

Every item of information should be carefully furnished. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6041 Yorkshire Dr
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Balto.
(If outside city or town limits write RURAL and give town)
(d) Street No. 6041 Yorkshire Dr.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Beulah Hollmann

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Frank
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 18, 1888

8. AGE: Years 58 | Months 69 | Days | If less than one day hr. min.

9. Birthplace Charlotte N. C.
(Town, county, and state)

10. Usual Occupation
11. Industry or business?

FATHER 12. Name ? Tennant
13. Birthplace N. C.

MOTHER 14. Maiden Name Sarah Plummer
15. Birthplace Perry

16 (a) Informant Frank Hollmann
(b) Address 6041 Yorkshire Dr

17 (a) Burial (b) Date thereof June 14 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or Crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Heeney Bros & Son
(b) Address 604 Harford Rd

19 (a) (b)
(Date rec'd by registrar) (By)

JUN 13 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11, 1947, at 7:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 1947, to 6-11 1947 and that I last saw h alive on 6-11 1947

Immediate cause of death: Carcinoma of uterine cervix

	Duration
Due to	2 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Dan Moore M. D.
Address 3105 Belair Rd Date signed 6-12-47

X

G52568

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

463

G52568 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3601 Keystone Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ada Stedman

3 (b) If veteran, name war: W

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Alexander S

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec 19, 1881

8. AGE: Years 65 | Months 5 | Days 21 | If less than one day: 24 hr. min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER
12. Name: Valentine Cook
13. Birthplace: Baltimore Md

MOTHER
14. Maiden Name: Martha Kerr
15. Birthplace: Baltimore Md

16 (a) Informant: Alexander I Stedman
(b) Address: 3601 Keystone Ave

17 (a) Sinai (Burial, cremation, or removal) (b) Date thereof: 6/16/47 (month) (day) (year)
(c) Cemetery or crematory: Lyndhurst
Location: Lyndhurst Md

18 (a) Funeral director: Tilhou & Doe
(b) Address: 1217 E Fort Ave

19 (a) JUN 14 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1947, at 11:53 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 13 1947 to June 12 1947, and that I last saw h.e.r. alive on June 12, 1947.

Immediate cause of death: Intestinal Obstruction, Malignancy of Pancreas

Due to: Cancer of Stomach.

Due to:

Other Conditions: Marked Sec. Anemia

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Leon Rosenbaum Jr. M.D.
Address: Sinai Hospital Balt. Md. Date signed: 6/13/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52569

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G52569

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5007 Anthony Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5007 Anthony Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Agnes Longmore

3 (b) If veteran, name war: W

3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife: Edward Leo

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Mr. 2. 1875

8. AGE: Years	Months	Days	If less than one day
71	7	9	hr. min.

9. Birthplace: Westminster Md
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: John McDonald
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Ellen Lynch
15. Birthplace: Ireland

16 (a) Informant: Edward Leo Longmore
(b) Address: 3722 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/14/47 (month) (day) (year)

(c) Cemetery or crematory: Holy Redeemer
Location: Baltimore Md

18 (a) Funeral director: Wilson & Son
(b) Address: 214 E. Lee St

19 (Date rec'd by registrar) JUN 14 1947 Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1947, at 10 46 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1946 to June 11 1947, and that I last saw her alive on June 11 1947.

Immediate cause of death: Cerebral hemorrhage — Duration: 2 days

Due to:

Due to:

Other Conditions: Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Charles J. Levasi
Address 4700 Parkwood Ave Date signed 6/13/47

VS 150

G52570

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH . 13B

Registered No. G52570

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 926 Bennett Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 18yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 926 Bennett Place
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Annie Mae Stevens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	colored	single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 13, 1929

8. AGE: Years	Months	Days	If less than one day
18	3	—	— hr. — min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Public school

11. Industry or business

FATHER
12. Name James Stevens
13. Birthplace Cambridge Md.

MOTHER
14. Maiden Name Gertrude Middleton
15. Birthplace Charles Co., Md.

16 (a) Informant James Stevens
(b) Address 926 Bennett Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-16-47 (month) (day) (year)
(c) Cemetery or crematory Christ's Meth. Epis.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Figuers A. Humphrey
(b) Address 578 W. Biddle St.

19 (a) JUN 14 1947 Washington Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 June 1947, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5.21.47 19 to 6.13.47 19, and that I last saw h[illegible] alive on 6.12.47 19

Immediate cause of death	Duration
Pulmonary Tuberculosis	July 1945?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James M. Lair M. D.
Address 4 E. Lexington Ave Date signed 6.13.47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given if possible. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52571

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G52571

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2422 E Baltimore St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2422 E Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helena Wisniewski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Married

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 77 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation House Work

11. Industry or business at Home

FATHER
12. Name Pusyzeki
13. Birthplace Poland

MOTHER
14. Maiden Name ?
15. Birthplace Poland

16 (a) Informant S Wisniewski
(b) Address 2422 E. Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 16/47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore

18 (a) Funeral director Fred W Ozarzuski
(b) Address 1930 Fountain Ave Baltimore, Md

19 (a) June 14 1947 (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1947, at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1947 to June 12 1947, and that I last saw h[illegible] alive on June 12 1947.

Immediate cause of death	Duration
Cardiac failure.	2.
Due to Cardio Vascular disease.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 200 S Hilton Date signed 6/13/47

VS 150

G52572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 131a

Registered No. G52573

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd Sts.
(c) Hospital or institution:
UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days
(e) Length of stay in Baltimore (yrs., mos., or days) [redacted]

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Walker Ave Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Walker Ave.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME EDMOND W. STABLER (Edmund Walsh Stabler)

3 (b) If veteran, name war	3 (c) Social Security Account No.
NONE	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Alice Lucretia Stabler
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Oct 23, 1888

8. AGE: Years	Months	Days	If less than one day
58	7	19	hr. min

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Railroader
11. Industry or business P. R. R. (Engineer)

FATHER
12. Name Edmund Stabler
13. Birthplace Maryland

MOTHER
14. Maiden Name Rebecca Caddy
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/14/47 (month) (day) (year)
(c) Cemetery or crematory Stabler's Cem.
Location Stablersville, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address North & Pa. Aves.

19 (a) JUN 13 1947 (Date received by Registrar) Huntington Williams Registrar

VS JUN 14-1947

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1947, at 3:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 1947, to June 12 1947, and that I last saw h[illegible] alive on June 12 1947.

Immediate cause of death	Duration
Uremia	2 wks
Due to Nephritis	10 yrs
Due to Hypertensive cardio Vascular disease	10 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward R Clarke M. D.
Address [redacted] Date signed 6-13-47

X Hospital, 33rd Calvert Sts Baltimore Md

G52573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

G52573 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 W. Cold Spring Lane
(c) Hospital or institution: Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 402 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 W. Cold Spring Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS ARTHUR LONG

3 (b) If veteran, name war: None
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Nannie Long
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 13, 1873

8. AGE: Years 73 | Months 8 | Days 28 | If less than one day hr. min.

9. Birthplace York, Penna. (Town, county, and state)
10. Usual Occupation Retired Electrician
11. Industry or business

FATHER
12. Name John Tarris Long
13. Birthplace York, Pa.

MOTHER
14. Maiden Name Elizabeth Horn
15. Birthplace York, Pa.

16 (a) Informant Mr. Walter Long
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 14th 1947 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 JUN 14 1947 Registrar Baltimore, Md.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11, 1947, at 4:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 16 1946 to June 11 1947, and that I last saw him alive on June 10 1947

Immediate cause of death: Pneumonia — Duration 4 days

Due to: Cerebral - Hemorrhage — 3 yrs

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas R. Kleman M. D.
Address 3803 Edmondson Date signed 6/17/47

G52574 — BALTIMORE CITY HEALTH DEPARTMENT — G52574

CERTIFICATE OF DEATH

Registered No. 87E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W. 40th St.,
(c) Hospital or institution: Home for Incurables
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Frederick
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W. 40th St. Home for Incurables
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cora Pauline Bines

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: none
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 15, 1902
8. AGE: Years 44 Months 8 Days 13 2d If less than one day hr. min.
9. Birthplace Frederick Co, Md (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Thos. Bantokes
13. Birthplace

MOTHER
14. Maiden Name Jane M. Biser
15. Birthplace Middletown, Md.

16 (a) Informant Home for Incurable Boards
(b) Address 700 W. 40th St. M. T. H.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 16, 1947 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location WOODLAWN, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

JUN 14 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13, 1947, at 5:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 12 1938, to June 13 1947, and that I last saw h[er] alive on June 12 1947

Immediate cause of death: Hydrocephalus — Duration: Several yrs

Due to: Staphylococcus Renal Calculi Pyelitis — Duration: Unknown

Due to:

Other Conditions: Congenital Spastic Paralysis — Duration: Since birth

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas Carmack Wolf, M. D.
Address 11 E. Chase St. Baltimore 2 Maryland
Date signed 6/13/47

VS 3

124a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52575 BCH 80685 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 159 G52575 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bon Secours Hospital
(c) Hospital or institution: 2026 W. Fayette St.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Rodgers Forge (If outside city or town limits, write RURAL and give town)
(d) Street No. 66 Dunkirk Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HARRY SANFORD RUNYAN, Jr.

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none
4. Sex: M.
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: -
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): June 10, 1947
8. AGE: Years -; Months -; Days 2; If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Henry Sanford Runyan, Sr.
13. Birthplace Pa.

MOTHER
14. Maiden Name Ethel Beatrice Janes
15. Birthplace Balto. Md.

16 (a) Informant Mr. Harry Runyan, Sr.
(b) Address 66 Dunkirk Rd., Rodgers Forge
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/14/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.
19 JUN 14 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1947 at 12:30 PM
21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1947 to June 12 1947, and that I last saw him alive on June 12 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to: severe prematurity	
Due to:	
Other Conditions: -	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: -
of autopsy: -

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William F. Barr M. D.
Address Bon Secours Hosp. Date signed 6-12-47

VS 150

G52576

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G52576

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1125 Fulton ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1125 Fulton ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Elenora Freeland (Freeman)

3 (b) If veteran, name war

3 (c) Social Security Account No. 247-03-5427

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife John Freeland

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-16-1894

8. AGE: Years 52 | Months 8 | Days - | If less than one day ..... hr. ..... min.

9. Birthplace Calvert Co. Md
(Town, county, and state)

10. Usual Occupation Home work

11. Industry or business own Home

FATHER
12. Name James Jones
13. Birthplace Calvert Co Md

MOTHER
14. Maiden Name Elizabeth Coates
15. Birthplace Calvert Co. Md

16 (a) Informant John Freeland
(b) Address 1125 Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-19-1947 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mrs Kytie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) [illegible] JUN 14 1947 Huntington Williamson, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-16-1947 4:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-2-1947 to 6-16-1947 and that I last saw her alive on 6-9-1947.

Immediate cause of death Cerebral hemorrhage — Duration 39 days

Due to Hypertension & arteriosclerosis — Duration unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: ?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Frank A. Saunders M. D.
Address 1029 N. Stricker Date signed 6-17-47

VS 150

G52577

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G52577
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland (Error-M)
(b) Street address 1523 Shield Place
(c) Hospital or institution:
Provident Hospital (M)
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-d-h
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 1523 Shield Place
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore
(If rural give location)
(e) Citizen of foreign country? Na (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Widowed

6 (b) Name of husband or wife Richard White
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28, 1901

8. AGE: Years	Months	Days	If less than one day
45	11	13	hr. min.

9. Birthplace Northumberland Co., Virginia
(Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Joseph Taylor
13. Birthplace Northumberland Co., Virginia

MOTHER
14. Maiden Name Ella Williams
15. Birthplace Northumberland Co., Virginia

16 (a) Informant Carrie Taylor
(b) Address 670 E. 120th St. New York City

17 (a) Burial (b) Date thereof 6/14/37
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Md

18 (a) Funeral director Geo. W. Kelson
(b) Address 1303 Greenmount Ave

19 JUN 14 1937 Huntington Williams, M.D.
(Date filed) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1937, at 9 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw her alive on 19

Immediate cause of death	Duration
Pericardial Tamponade with rupture aortic Aneurysm	1 day
Due to Hypertensive Cardiovascular Disease	1 yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Rupture of Aortic Aneurysm c tamponade

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address Date signed 6/13/37

G52578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G52578

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Give correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 HARFORD AVE
(c) Hospital or institution:
CONVALESCENCE HOME.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6MONTHS
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4622 WALTHERS BOULEVARD.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH THERESA HOUSTON.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife John O. Houston

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 5th, 1872

8. AGE: Years 75 | Months 2 | Days 8 | If less than one day ....hr. ....min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name John F. Carroll
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Sophia L. Schermer
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Lillian Ackerman
(b) Address 4622 Walther Blvd.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 6/16/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. North Ave at Rose St.

18 (a) Funeral director Lasnahn Funeral Home
(b) Address 7401 Belair Road

19 JUN 14 1947 (Date rec'd by Reg.) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 13 1947 19 , at 6.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from APRIL 8 1947 to JUNE 13 1947 and that I last saw her alive on JUNE 13 1947

Immediate cause of death	Duration
CARCINOMIA OF BREAST APRIL (RECURENT)	8 1947
Due to METASTASIS	1947.
Due to CHRONIC ARTHRITIS.	1946.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 1932.
Major findings of operation: CARCINOMIA BREAST.
of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ....at ....M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lucius O'Brien Swift
3013 ST PAUL STREET JUNE 13 1947
Address Date signed

VS 150

G52579 X G52579

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Light St
(c) Hospital or institution: Bon Balto G.H.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6827 Holabird Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Wilhelmina Strathmann (STRATHMANN)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife George H. Strathmann
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 6, 1899

8. AGE: Years	Months	Days	If less than one day
47	6	8	hr. min.

9. Birthplace Balto. Co. Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Koenig
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Helena Homberg
15. Birthplace Balto. Md

16 (a) Informant Mrs. H. Herman Strathmann
(b) Address 6827 Holabird Ave. Balto.

17 (a) Burial (b) Date thereof 6/17/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Dalby Md

18 (a) Funeral director Rogers-Burr Funeral Home
(b) Address 7401 Belair Road Balto. Md

19 JUN 14 1947 Huntington Williams M.D.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-14 1947 at 3:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-12 1947 to 6-14 1947 and that I last saw her alive on 6-14 1947

Immediate cause of death	Duration
Pneumonia, bilateral	
Due to Cerebral Hemorrhage	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M. D.
Address 5 E. 39th St Date signed 6-17-47

VS 150

G52580

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G52580

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Give correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2600 E Fayette St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2600 E Fayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bridget Hunt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife James Hunt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26-1865

8. AGE: Years	Months	Days	If less than one day
82	4	18	hr. min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation
11. Industry or business At Home

FATHER 12. Name John O'Connor
13. Birthplace Ireland

MOTHER 14. Maiden Name Cusight
15. Birthplace Ireland

16 (a) Informant Elizabeth M. Hunt
(b) Address 2600 E Fayette St

17 (a) Burial (b) Date thereof June 16/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Road

18 (a) Funeral director John C Moser
(b) Address 3600 E Baltimore St

19 JUN 14 1947 (b)
(Date rec'd by registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-14-46 19 to 6-12-1947 and that I last saw h alive on 6-12-1947

Immediate cause of death	Duration
ARTERIOSCLEROTIC HEART DISEASE	5 YEARS
Due to ARTERIOSCLEROSIS	10 YEARS
Due to	
Other Conditions PARKINSONS DISEASE.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benj. A. Moser, M.D.
M. D.
Address 448 N. Lafayette Ave Date signed 6-17-47

G52581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92E

Registered No. G52581

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1529 W. Lombard St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1529 W. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary F. Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24, 1860

8. AGE: Years 86 | Months 11 | Days 18 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER 12. Name Joseph Thomas
13. Birthplace Baltimore

MOTHER 14. Maiden Name Elizabeth Colhouer
15. Birthplace Baltimore

16 (a) Informant Mrs Maggie Primrose
(b) Address 1529 W. Lombard St.

17 (a) Burial (b) Date thereof 6-16-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore

18 (a) Funeral director Jas. A. Cole
(b) Address 1200 Lombard St.

19 (a) JUN 14 1947 Washington Williams M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12, 1947 at 9:30 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1947 to June 12 1947 and that I last saw h.... alive on June 12 1947.

Immediate cause of death Cardiac arrest — Duration unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter F. Bowen

Address 400 Edmondson Ave Date signed 6/17/47

V S 150

X

G52582

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

837

Registered No. G52582

TN. 69725

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 yrs. 7 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 734 Hengal Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John David Cook

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Sept.

6 (b) Name of husband or wife: Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25th 1872

8. AGE: Years 74 | Months 5 | Days 15 16 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John David
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Ellen Robinson
15. Birthplace Eastern Shore

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 14-1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Baltimore md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley ave Huntington Williams Md

19 (a) June 14 1947 (b) Registrar

MEDICAL CERTIFICATION A.M.

20. DATE OF DEATH June 10th 1947 19..., at 7.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 3rd 19 41. to June 10 19 47. and that I last saw h in alive on June 10th 19 47.

Immediate cause of death: Bronchopneumonia — Duration: 4 da

Due to: unknown cause

Due to:

Other Conditions: (1) Right hemiplegia (2) Generalized arteriosclerosis — 6 years
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edwina C. Evans M. D.
Address Balto. City Hospitals Date signed 6-11-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied if correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V S 150

107

G52583

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G52583

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1502 Harlem Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1502 Harlem Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DENNIS L. HEAVRON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace A A. Co. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Levi Heavron
13. Birthplace Md

MOTHER 14. Maiden Name Charlott
15. Birthplace Md

16 (a) Informant Matilda Gross
(b) Address 1502 Harlem ave

17 (a) Burial (b) Date thereof June 17-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cem
Location Brooklyn Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bloomley ave

19 (a) JUN 14 1947 Interring for Williams M.E.
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11, 1947, at 1.30 P M

21. I certify that I took charge of the remains described above, held an insp.& inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Bryd M.D.
Medical Examiner.
Date signed 6-12-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52584 Perry

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131 B

Registered No. G52584

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Where correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 300 N. Eden St
(c) Hospital or institution: 5-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 300 N. Eden St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James H Taylor

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	~~M~~

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
51			hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Labor
11. Industry or business

FATHER
12. Name Jim Taylor
13. Birthplace Va

MOTHER
14. Maiden Name Louise Adkins
15. Birthplace Va

16 (a) Informant Cater Waters
(b) Address 300 N. Eden St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 15-1947 (month) (day) (year)
(c) Cemetery or crematory
Location Stony Creek Virginia

18 (a) Funeral director Elmore Wilson
(b) Address 1010 Bentley ave

19 (a) Date received by registrar JUN 14 1947 (b) Registrar Washington Millsaps M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 · 11 · 1947 at 7:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6 · 9 1947 to 6 · 11 1947 and that I last saw h[illegible] alive on 6 · 11 1947.

Immediate cause of death	Duration
Uremia	1 day
Due to Nephritis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. L. Dorsey M. D.
Address 1420 E. Chase Date signed 6 · 13 · 47

C52585

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 50

C52585 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1429 E. Eager St
(c) Hospital or institution: —
10

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 13
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1429 E. Eager St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Lucy E. Wright

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	N	Widowed

6 (b) Name of husband or wife Grant Wright
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 11 1888

8. AGE Years	Months	Days	If less than one day
58	6	12	hr. min.

9. Birthplace Marie Virginia
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Robert Jeett
13. Birthplace Virginia

MOTHER
14. Maiden Name Winnie —— ?
15. Birthplace Virginia

16 (a) Informant Floyd Jones
(b) Address 1429 E. Eager St

17 (a) Removal (b) Date thereof June 14/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Fredricksburg Va

18 (a) Funeral director Mrs. Ruth A Ellett Dgt
(b) Address 1129 N. Carlton St

19 (a) JUN 14 1947 Wilmington, Del.
(Delivered to registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1947, at 4:28 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1946 to June 1947, and that I last saw h[illegible] alive on June 1 1947

Immediate cause of death	Duration
Hypertensive cardio-vascular disease	4 yrs
Due to Diabetes	4 yrs
Due to Arteriosclerosis	4 mos
Other Conditions Dry Gangrene both feet	1 yr

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. J. Stapleton, M.D.
Address 1432 E. Chase St Date signed 6/13/47

VS 150

61

G52586

AB-110940

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 43B

Registered No. G52586

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals ✓

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1408 E. Fairmount Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Nancy Long

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col.	?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?-? 1876

8. AGE: Years	Months	Days	If less than one day
71?	?	?	hr. min.

9. Birthplace ? (Town, county, and state)
10. Usual Occupation On Old Age Assistance
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 16/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location 4-9 County Md.

18 (a) Funeral director Mrs. Ella Gelbrich
(b) Address 1299 Carlisle St.

19 (a) JUN 14 1947 (Date rec'd by registrar) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1947, at 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-26- 1947 to 6-12 1947, and that I last saw her alive on 6-12 1947

Immediate cause of death	Duration
Circulatory Failure	
Due to Bronchopneumonia	4 days
Due to Rt. Hemiplegia due to Cerebral Embolism	
Other Conditions Pyelitis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. R. Scarborough M. D.
Address Balto City Hosp. Date signed 6-19-47

G525387

AB-102935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 82

Registered No. G525387

Please write plainly with pen and ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals 6

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10mos-27days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No. 419 N. Linwood Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Claude McIntyre

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10- 1898

8. AGE: Years	Months	Days	If less than one day
48	8	3	hr. min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER	12. Name Lum McIntyre
	13. Birthplace Md.
MOTHER	14. Maiden Name Mary McIntyre
	15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) BURIAL (b) Date thereof 6-16-47

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory MT VERNON CEM

Location MT VERNON MD

18 (a) Funeral director DALE DASHIELL

(b) Address PRINCESS ANN.

JUN 14 1947

(Date rec'd by registrar) (b) Washington Williams, M.D.

V S 190

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1947, at 10.55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-16- 1946 to 6-13- 1947 and that I last saw h im alive on 6-13- 1947

Immediate cause of death	Duration
Respiratory Failure	
Due to Congestion	2 Days
Due to Lateral Sclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Yes

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature J. C. Robinson Jr. M. D.

Address Balt. City Hosp. Date signed 6/14/47

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G52588 X 54a G52588 Registered No.

Every item of information should be carefully supplied. (The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Wicomico
(c) City or town Salisbury (If outside city or town limits, write RURAL and give town)
(d) Street No. Rt. # 1 (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Willie Hill

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Savary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-30-95

8. AGE: Years 52 | Months 4 | Days 15 | If less than one day hr. min.

9. Birthplace W. Va. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name William Hill
13. Birthplace W. Va.

MOTHER 14. Maiden Name Lizzie ?
15. Birthplace W. Va.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-16-47 (month) (day) (year)
(c) Cemetery or crematory Smullen Cemetery
Location Worcester County Md.

18 (a) Funeral director Holloway & Co.
(b) Address Salisbury, Md.

19 (a) (Date received by registrar) (b) Registrar

JUN 15 1947

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 1947 at 11:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 11 1947 to June 14 1947 and that I last saw him alive on June 14 1947.

Immediate cause of death	Duration
Shock	
Due to Operation for	
Due to Brain tumor, Glioma	4 days
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 6-14-47

Major findings of operation: Glioma st. cerebral lobe

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. B. Morrow M. D.
Address J. H. H. Date signed 6-14-47

X

G52589
AB-111284

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30E

G52589
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3days
(e) Length of stay in Baltimore (yrs., mos., or days) 46yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 906 N. Gay Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Smith

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col.	Widowed

6 (b) Name of husband or wife Willie (D
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 30- 1894

8. AGE: Years	Months	Days	If less than one day
52	8	12	hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Patrick Green (D
13. Birthplace Virginia

MOTHER
14. Maiden Name Theresa Jones (D
15. Birthplace Virginia

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 6/15/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Balto. Co. Md.

18 (a) Funeral director Joseph L. Lott
(b) Address 1364 N. Central Ave

19 (a) JUN 15 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12- 1947, at 7.10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-9- 1947 to 6-12- 1947 and that I last saw h.. alive on 6-12- 1947

Immediate cause of death	Duration
Cardiac Insufficiency	3 months
Due to Syphilitic Cardiovascular disease with Aortic Insufficiency	2 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.
Address Baltimore City Hospitals Date signed 6-18-47

G52590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

G52590 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write as completely as possible.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1359 Riverside Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES F. HASSELBERGER

3 (b) If veteran, name war

3 (c) Social Security Account No. 153-01-7023

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28, 1896

8. AGE: Years 50 | Months 10 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Pile Driver

11. Industry or business Construction

FATHER 12. Name Ferdinand Hasselberger

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name ? Brauns

15. Birthplace Baltimore Md

16 (a) Informant James Earl Talley

(b) Address 2509 Sydney Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 16/47 (month) (day) (year)

(c) Cemetery or crematory Holy Cross Cemetery

Location Ritchie Highway

18 (a) Funeral director Elizabeth Kelly Inc.

(b) Address 115 E. Lee West St.

(c) (d) Registrar

JUN 15 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/13/47 19 , at 5:00 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Hes death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Generalized Carcinomatosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury X at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Devers M.D.
Medical Examiner.
Date signed 6/14/47

VS 151

X

G52591 BALTIMORE CITY HEALTH DEPARTMENT G52591
CERTIFICATE OF DEATH 46E
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5001 Chalgrove Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5001 Chalgrove Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Goldfarb
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Late Nathan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
about 75			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business House Wife

FATHER
12. Name Unkown
13. Birthplace Russia

MOTHER
14. Maiden Name Bessie Goldfarb
15. Birthplace Russia

16 (a) Informant Jerome Goldfarb
(b) Address 5001 Chalgrove Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 15, 1947 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel Cem
Location German Hill Road
18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave
(Date received) (b) (Registrar)
JUN 16 1947 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION
20. DATE OF DEATH June 14 1947, at 9 P.M
21. I certify that death occurred on the date above stated; that I attended deceased from June 7 1947, to June 14 1947, and that I last saw her alive on June 14 1947.

Immediate cause of death Cardiac failure — Duration 1 week
Due to Carcinoma of Bowel — Duration 1 year
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Joseph K. Silverman M.D.
Address 4145 Park Heights Ave Date signed June 15, 1947

G52592 BALTIMORE CITY HEALTH DEPARTMENT G52592
Registered No.

CERTIFICATE OF DEATH 46E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Fill correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2212 WHITTIER
(c) Hospital or institution: 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2212 WHITTIER AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA L. REZNICK

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	M

6 (b) Name of husband or wife MAY
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years	Months	Days	If less than one day
58			hr. min.

9. Birthplace BALTO MD (Town, county, and state)
10. Usual Occupation HOUSE WORK
11. Industry or business

FATHER
12. Name BENJ. LEBOVITZ
13. Birthplace RUSSIA

MOTHER
14. Maiden Name HANNAH
15. Birthplace RUSSIA

16 (a) Informant HUSBAND
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 6-14-47 (month) (day) (year)
(c) Cemetery or crematory ROSEDALE
Location Phila. PA

18 (a) Funeral director Jack Levy Inc
(b) Address 1439 E. Baltimore St
(c) 6 15 1947 Huntington Williams, M.D. Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/13/47 19 ; at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 47 to June 13 19 47, and that I last saw h. alive on June 13, 1947.

Immediate cause of death	Duration
Carcinoma of Colon	
Due to	
Due to	
Other Conditions Metastases	

(Include pregnancy within 3 months of death)
Date of operation Feb. 1 1947
Major findings of operation: Carcinoma
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Sidney L. Levy M. D.
Address 2312 Eutaw Place Date signed 6/14/47

VS 150

G52593

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G52593 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 500 W. 37th Street
(c) Hospital or institution: —
13
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 500 W. 37th Street
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Robert Goodman

3 (b) If veteran, name war: 1st World War
3 (c) Social Security Account No. unknown

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife: Dorothy Goodman
6 (c) If alive, give age: 36 years

7. Birth date of deceased (mo., day, yr.) June 15, 1901

8. AGE: Years	Months	Days	If less than one day
46	11	0	hr. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation: motion picture manager
11. Industry or business: motion Picture

FATHER
12. Name: Wm. Goodman.
13. Birthplace: Russia

MOTHER
14. Maiden Name: Lena Freed
15. Birthplace: Russia

16 (a) Informant: Dorothy Goodman.
(b) Address: 500 W. 37th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-16-47 (month) (day) (year)
(c) Cemetery or crematory: Balto Hebrew
Location: Belair Rd.

18 (a) Funeral director: Jack Levin Inc
(b) Address: 210 Eutaw Place

19 (a) [illegible] (b) [illegible] Registrar

JUN 15 1947
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 14 June 1947, at 6:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1941, to June 14 1947, and that I last saw him alive on 8 June 1947.

Immediate cause of death: Coronary occlusion.

	Duration
Due to —	
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operations: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature: William Goodman M. D.
Address: 1294 Sulphur Spring Road Date signed 14 June 1947
Rabbi, 27, md

G52594

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 192 B

Registered No. G52594

PLEASE WHITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway and Fairmount
(c) Hospital or institution: Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hour
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore-24 (If outside city or town limits, write RURAL and give town)
(d) Street No. 616 Fait Ave (If rural give location)
(e) Citizen of foreign country? ND (Yes or No)
If yes, name country

3 (a) FULL NAME Claude Grimes

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. none
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Amelia Grimes
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 14 1887
8. AGE: Years 60 | Months 2 | Days 0 | If less than one day ____hr. ____min.
9. Birthplace Baltimore Maryland (Town, county, and State)
10. Usual Occupation Disabled Veteran
11. Industry or business

FATHER
12. Name Jerome Grimes
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Mokesworth
15. Birthplace Maryland

16 (a) Informant Mrs. Amelia Grimes
(b) Address 616 Fait Ave, Balto 24
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/18/47 (month) (day) (year)
(c) Cemetery or crematory U. S. National
Location Balto. Md.
18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St

JUN 16 1947 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 1947 at 10: M

21. I certify that death occurred on the date above stated; that I attended deceased from June 14 1947 1 hour 19__, and that I last saw h/M alive on June 14 1947.

Immediate cause of death	Duration
Cardiac failure	
Due to Mitral stenosis and insufficiency	
Due to Rheumatic Heart Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: not performed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature David Buchanan M. D.
Address Church Home & Hosp. Date signed 6/19/47

VS 150

X

G52595

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓30E

Registered No. G52595

AB-111212

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7days
(e) Length of stay in Baltimore (yrs., mos., or days) 51yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 602 N. Carey St. zone 17
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert James

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Caroline

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2- 1895

8. AGE: Years 52 | Months 0 | Days 11 | If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER
12. Name Charles James (D
13. Birthplace Va.

MOTHER
14. Maiden Name Hester ?
15. Birthplace Va.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 18-47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location

18 (a) Funeral director James A Stevens
(b) Address 142 W Hill St

19 (Date received by registrar) JUN 16 1947 (b) Huntington Hilligross M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13- 1947, at 5.50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-6- 1947 to 6-13- 1947, and that I last saw him alive on 6-13- 1947

Immediate cause of death: Tb Meningitis — Duration: 1 wk

Due to

Due to (or) Syphilitic

Other Conditions Hypertension Heart Disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J C Rabenaga Jr M. D.

Address Bal. City Hosp Date signed 6/19/47

TRANSCRIBE FACTS CAREFULLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52596

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BCH # 77137 / 119a

Registered No. G52596

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 41 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1502 Fatalle ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Scanlon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-27-47

8. AGE: Years | Months 1 | Days 11 | If less than one day ____ hr. ____ min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Crispen
13. Birthplace Md.

MOTHER
14. Maiden Name Caroline Scanlon
15. Birthplace Md.

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Loretto JUN 9 1947

18 (a) Funeral director Commissioner of Health

(b) Address

JUN 16 1947 (Date received by Registrar) (Huntington Williams, M.D. Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-8-1947, at 7:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-5-47, to 6-8-1947, and that I last saw h[illegible] alive on 6-8-1947.

Immediate cause of death Duodenal Ulcer, Severe Hemorrhage — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. Rosenzweig M. D.
Address Johns Hopkins Hosp. Date signed 6-9-47

PRESS WHITE FIRMLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 190

G52597 Blk 19923 5N 425

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1602

G52597
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1402 E. Preston St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Ramsey.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-2-47

8. AGE: Years	Months	Days	If less than one day
		4.	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Hedricks Ramsey.
13. Birthplace M.D.

MOTHER 14. Maiden Name Ann Rogers
15. Birthplace N.C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Loc JUN 9 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUN 16 1947 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION A

20. DATE OF DEATH June-6 1947, at 9.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from June-2 1947, to June-6 1947, and that I last saw her alive on June-6 1947

Immediate cause of death	Duration
prematurity	
Atelectasis	
Intracranial hemorrhage	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Phillips Cornbrooks Jr. M.D.
Address Johns Hopkins Hosp. Date signed 6-7-47

VS 150

X

G52598 Bl#6-79185 G52598

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V159

Registered No.

Every item of information should be carefully supplied. The space write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Even if exact age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 6 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2824 Booth Alley (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Baby J Marian Baptist

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-22-47

8. AGE: Years	Months	Days	If less than one day
			6 hrs. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Albert Baptist
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Marian Jaime
15. Birthplace Camden N. J.

16 (a) Informant Marian Baptist
(b) Address 2824 Booth Alley

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School JUN 12 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUN 16 1947 (Date filed by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-22- 1947, at 11 55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-22- 1947, to 5 pm 5-22- 1947, and that I last saw him alive on 5-22- 1947.

	Duration
Immediate cause of death atelectasis	
Due to Prematurity	31 wks
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Baetjer M. D.
Address 715 E. Fayette St. Date signed 5-24-47

VS 130

G52599 Birth Certificate G-52599 Dec 680487

G52599

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 154

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 857 W. Balto St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Beasley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Black

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-7-47

8. AGE: Years | Months | Days | If less than one day: 1 hr. — min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Sam Beasley
13. Birthplace Va.

MOTHER 14. Maiden Name Estella Greene
15. Birthplace S.C

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo JUN 9 1947

18 (a) Funeral director Commissioner of Health
(b) Address

JUN 16 1947 (Date rec'd by registrar) Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-7 1947, at 5:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-4 1947, to 19; and that I last saw him alive on 6-4 1947

Immediate cause of death - DOA prematurity

Due to prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Julian Chisolm Jr.

Address Johns Hopkins Hosp. Date signed 6-7-47 M.D.

VS 190

G52600

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G52600

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins (DOA)
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 426 S. Cornwall St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3 (a) FULL NAME Martin Schultz

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	213-10-0828

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Frances Berdzinska 6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Nov. 13, 1877

8. AGE: Years	Months	Days	If less than one day
69	7	1	..... hr. ..... min.

9. Birthplace Poland - Germany (Town, county, and state)
10. Usual Occupation Sexton
11. Industry or business

FATHER 12. Name Michael Schultz
13. Birthplace Germany - Poland

MOTHER 14. Maiden Name Theodora Karsinska
15. Birthplace Germany - Poland

16 (a) Informant Frances Schultz
(b) Address 426 S. Cornwall St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/17/47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Gorman Hill Rd.

18 (a) Funeral director M. W. E. Degele's Sons
(b) Address 1211 Gerard & Hoyt Sts.

JUN 16 1947 (Date received by local registrar) Thurlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 June 1947, at 12:00 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Wm. H. Kammer, Jr. M.D. Medical Examiner.
Date signed 14 June 1947

VS 191

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G52601

PRINT OR WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor Ave & Dukeland St
(c) Hospital or institution West Baltimore Gen. Hosp 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1610 No. Appleton St. 17
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Hattie Small

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	WHITE	Widow

6 (b) Name of husband ~~or wife~~ Philip Small
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24, 1879

8. AGE: Years	Months	Days	If less than one day
68		15	hr. min.

9. Birthplace Columbia City, Ind.
(Town, county and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Nathan Lipka,
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Sabbag,
15. Birthplace Germany

16 (a) Informant Mrs. Norman Simms
(b) Address 1610 N. Appleton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/17/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director Sherin Sonnheim & Son
(b) Address 1900 Eutaw Place

19 JUN 16 1947 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1947, at 2:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-13 1947 to 6-15 1947 and that I last saw her alive on June 15 1947.

Immediate cause of death	Duration
Cerebral vascular thrombosis	
Due to Arteriosclerotic cardiovascular disease	
Due to	
Other Conditions Diabetes mellitus	7 years

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations None
of autopsy Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Donald F. Gleason M. D.
Address 2834 St Paul St. Date signed 6-15-47

93

Dr. C. Peake

G52602

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

516

Registered No. G52602

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2809 Fleetwood Ave.
(c) Hospital or institution:

77

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4607 Mainfield Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Ludwig, (Louis) Ellenberger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife: Caroline
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 14, 1869

8. AGE: Years	Months	Days	If less than one day
77	9	29	hr. min.

9. Birthplace: Germany
(Town, county, and state)
10. Usual Occupation: Retired
11. Industry or business: Baker

FATHER
12. Name: Justus Ellenberger
13. Birthplace: Germany

MOTHER
14. Maiden Name: Elizabeth Margraf
15. Birthplace: Germany

16 (a) Informant: Mrs. Caroline Ellenberger
(b) Address: 2809 Fleetwood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/16/47 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore, Md.

18 (a) Funeral director: Leonard J. Ruck
(b) Address: 5305 Harford Road, 14

19 JUN 16 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-19 1947 to 6-12 1947.
and that I last saw h alive on 6-11 1947

Immediate cause of death: Carcinoma Prostate — Duration: 6 Mo.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 4-23-47

Major findings of operation: Carcinoma Prostate

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: L. W. Peake M. D.
Address 4505 Harford Rd Date signed 6-17-47

VS 150

X

Dr. Golley

G52603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G52603

FORMS WHITE COUNTY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2209 Kentucky Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2209 Kentucky Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Theodore W. Pieper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife: Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 12, 1878

8. AGE: Years	Months	Days	If less than one day
69	5	3	hr. min.

9. Birthplace: New York (Town, county, and state)

10. Usual Occupation: Acct.

11. Industry or business

FATHER
12. Name: Charles Pieper
13. Birthplace: ?

MOTHER
14. Maiden Name: ?
15. Birthplace: ?

16 (a) Informant: Mrs. T. J. Von Rinteln
(b) Address: 2209 Kentucky Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/18/47 (month) (day) (year)
(c) Cemetery or crematory: Lutheran Cem.
Location: New York City.

18 (a) Funeral director: Leonard J. Ruck
(b) Address: 5305 Harford Road, 14

19 (a) JUN 16 1947 (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15th, 19 47. M

21. I certify that death occurred on the date above stated, that I attended deceased from 5/15 1947 to 6/15 1947 and that I last saw h[illegible] alive on 6/15 1947

Immediate cause of death: Coronary Thrombosis — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: [illegible] Golley M. D.
Address 5403 Harford Rd. Date signed 6/16/47

X

G52604

BALTIMORE CITY HEALTH DEPARTMENT X N
CERTIFICATE OF DEATH 46B

Registered No. G52604

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Rural - Reisterstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander Halliday

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years	Months	Days	If less than one day
42			hr. min.

9. Birthplace Bardonsville, Va.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Edward Halliday
13. Birthplace Va.

MOTHER
14. Maiden Name Maggie Cadlick
15. Birthplace Va.

16 (a) Informant Elizabeth Halliday
(b) Address 412 Rhode Island Ave, N.W.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-16-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director E Rankin L Law
(b) Address 1022 Madison Ave

JUN 16 1947 (Date rec'd by registrar) (b) Hunting for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-12 1947, at 7:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-27 1947 to 6-12 1947, and that I last saw h.. alive on 6-12 1947

Immediate cause of death	Duration
Respiratory failure	
Due to carcinoma of stomach with metastasis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: carcinoma of stomach
of autopsy: carcinoma of stomach

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J B Hartley, MD M. D.
Address U Hospital Date signed 6-14-47

VS 190

Dr. Louis Zimmerman
2858 Harford Road

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93D

Registered No. 652605

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3104 Rosalie Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3104 Rosalie Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GERTRUDE H. BRAEMER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife John A. Braemer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1887

8. AGE: Years	Months	Days	If less than one day
59	6	18	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Henry H. Rowe
13. Birthplace Pa.

MOTHER
14. Maiden Name Hannah Dohoney
15. Birthplace Pa.

16 (a) Informant Mrs John A. Braemer
(b) Address 3104 Rosalie Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-17-47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 (a) JUN 16 1947 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 14th, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1946 to June 1947 and that I last saw her alive on 13 June 1947

Immediate cause of death Cerebrovascular Accident } 7 days +

Due to Arteriosclerosis 1 day

Due to 10 yrs. ?

Other Conditions Arteriosclerotic cardio-vascular disease 10 years
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis H. Zimmerman M.D.
Address 2858 Harford Rd. Date signed 16 June 47

83a

G52606

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. G52606

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 130 S Patterson Pk Ave
(c) Hospital or institution: St Joseph's Home for the aged
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 130 S Patterson Park Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes M. Wydra

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife Adalbert Wydra

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 6 1865

8. AGE: Years 82 | Months 81 | Days 5 | 9 | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Jan Stachura
13. Birthplace Poland

MOTHER
14. Maiden Name Maryanna
15. Birthplace Poland

16 (a) Informant Rev Damian Wydra
(b) Address Elliott City Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 18 1947 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Dundalk ave

18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson St.

19 JUN 16 1947 (Date rec'd by Registrar) Huntington Williamsburg Md (City or Town)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1947 at 1:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 7 1946 to June 15 1947
and that I last saw h Sr alive on June 10 1947

Immediate cause of death: BRONCHIGENIC CARCINOMA — Duration: 3?

Due to:

Due to: 1- ABDOMINAL HERNIA — 2?
2 ARTERIOSCLEROTIC HYPER- — ?

Other Conditions: TENSIVE CARDIO-VASC. DIS.
(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rev Damian F Wydra O.F.M.

Address 20 W Chester St Date signed 6/16/47 M. D.

READ WHITE HEADING, WITH TYPEWRITER OR PEN AND INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52607

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G52607

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 714 Dolphin
(c) Hospital or institution:
17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 714 Dolphin
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ellsworth A. Evans

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	M

6 (b) Name of husband or wife Marie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1-1881

8. AGE: Years	Months	Days	If less than one day
66	5	11	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name Henry Evans
13. Birthplace Md

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace Md.

16 (a) Informant Marie Evans
(b) Address 714 Dolphin St

17 (a) B (Burial, cremation, or removal) (b) Date thereof 6-16-47 (month) (day) (year)

(c) Cemetery or crematory Arbutus
Location Balto. Co.

18 (a) Funeral director Samuel W. Sullivan & Son
(b) Address 1011 W. Lafayette Ave

19 (a) JUN 16 1947 (Date rec'd by registrar) Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1947, at 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1947 to June 12 1947 and that I last saw h alive on June 11 1947

Immediate cause of death

Cardiac Vascular Renal — Duration not kn

Due to Arterial

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles J. Wardlaw M. D.
Address 861 Sterling Date signed 6-16-47

X

G52608

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. G52608

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 318 N. Preston St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 318 N. Preston St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Jerry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1883

8. AGE: Years 64 | Months - | Days 29 | If less than one day hr. min.

9. Birthplace Crewe, Va
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name ? ? Dyer
13. Birthplace Crewe, Va

MOTHER
14. Maiden Name Unknown
15. Birthplace Nottoway Co. Va

16 (a) Informant Mrs. Louise Jones
(b) Address 318 N. Preston St.

17 (a) Burial (b) Date thereof June 16, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. Chas. H. Hollang
(b) Address 1631 Druid Hill Ave

19 (c) JUN 16 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14, 1947, at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-9 1947 to 6-14 1947, and that I last saw h[illegible] alive on 6-14 1947

Immediate cause of death	Duration
Hypertension	17 yr
Cerebro Vascular	
Due to Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Atwell Jones M.D.

Address 23-4 Wolfe St. Date signed 6-16-47

V S 150

X

052609

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 052609

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 922 N. Carrollton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 922 N. Carrollton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josie A. Burrell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife John Edward

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 28, 1900

8. AGE: Years 47 | Months 4 | Days 15 | If less than one day hr. min.

9. Birthplace Accomac Co. Va
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name James A. Conquest
13. Birthplace Accomac Co. Va

MOTHER
14. Maiden Name Emily Duell
15. Birthplace Accomac Co. Va

16 (a) Informant Mr. John E. Burrell
(b) Address 922 N. Carrollton Ave.

17 (a) Burial (b) Date thereof June 16, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Thos. Leo H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) Filed JUN 16 1947 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1947, at 4.55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from — 1942 to 6-12 1947 and that I last saw her alive on 6-10 1947.

Immediate cause of death	Duration
Coronary Heart Disease	4 mos.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert R. Lindsay M.D.

Address 2029 Madison Ave. Date signed 6/16/47

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G52610

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G52610

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dept
(c) Hospital or institution: John Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 927 S. Durham St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Garrett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife Single

6 (c) If alien, give age years

7. Birth date of deceased (mo., day, yr.) June 21, 1865

8. AGE: Years 81 | Months 11 | Days 23 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name James Garrett
13. Birthplace Unknown

MOTHER
14. Maiden Name Sarah J. Baskes
15. Birthplace Hickenthorn

16 (a) Informant Billy May Garrett
(b) Address 32 ½ Durham St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/16/47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Pennsylvania Blvd

18 (a) Funeral director John F. Keyser Jr.
(b) Address 714 Light St.

19 (a) JUN 16 1947 (Date rec'd by registrar) Washington Hollinsworth

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/14 1947, at 1:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiac Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature E. P. Schmidt M.D.
Medical Examiner.
Date signed 6/14/47

VS 151

Use ink or typewriter. Physicians: please write the causes of death clearly and legibly.

C52611

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93a

Registered No. C52611

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Balto md
(b) Street address 863 Vine St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 863 Vine St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Washington

3 (b) If veteran, name war: 1st World War
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: C.d
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Surrender
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1898

8. AGE: Years 49 | Months 2 | Days | If less than one day ____ hr. ____ min.

9. Birthplace Balto. md (town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Charles Washington
13. Birthplace Va

MOTHER
14. Maiden Name Ida Johnson
15. Birthplace Balto. Md

16 (a) Informant Mrs. Laura Washington
(b) Address 863 Vine Alley

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-16-47 (month) (day) (year)
(c) Cemetery or crematory National
Location Farrington

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Belnord Ave

19 (Date received by registrar) JUN 16 1947 (Huntington Williams, Jr.)

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-11-1947 at 3A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-7-1947 to 6-11-1947 and that I last saw h[illegible] alive on 6-11-1947

Immediate cause of death: Acute Myocardial Infarction — Duration: 4 D

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address [illegible] Date signed 6/16/47

VS 150

G52612

BALTIMORE CITY HEALTH DEPARTMENT

BCH B80860 CERTIFICATE OF DEATH 159

Registered No. G52612

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2035 DRUID PK DRIVE
(c) Hospital or institution: HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1/24 hr
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTO,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1603 DURHAM
(If rural give location)
(e) Citizen of foreign country? AM (Yes or No)
If yes, name country

3 (a) FULL NAME PATRICK O'MALLEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 15 JUNE 47

8. AGE: Years	Months	Days	If less than one day
0	—	—	0 hr. 20 min.

9. Birthplace BALTIMORE, MD
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name MR. FRANCIS X O'MALLEY
13. Birthplace BALTO. MD

MOTHER
14. Maiden Name ~~Mrs~~ LILLIAN KROOT
15. Birthplace BALTO, MD

16 (a) Informant MRS LILLIAN O'MALLEY
(b) Address 1603 DURHAM ST

17 (a) Burial (b) Date thereof 6-16-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Bpeta MD

18 (a) Funeral director Geo. A. Fahey
(b) Address Fulton Ave & Fayette

19 (a) Date received JUN 16 1947 (b) Registrar Huntington Williamson

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 JUNE 1947, at 8:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7:45-15 June 47, to 8:10 15 June 47, and that I last saw him alive on 15 JUNE 1947.

Immediate cause of death	Duration
PREMATURITY	
Due to	
Due to	
Other Conditions NONE	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: NONE
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas P. O'Rourke M. D.
Address 2722 Monument St. Date signed 15 June 47

VS 150

52613 BC# 945655

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1941

Registered No. 52613

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Home
(c) Hospital or institution: 618 E 28th St.
(d) Length of stay in hospital or inst. (yrs., mos., or days) da a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 618 E 28th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roland Rice

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/15/46

8. AGE: Years 1 | Months 2' | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Waldin Rice

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Adeline Snead

15. Birthplace Baltimore Md

16 (a) Informant Adeline Rice

(b) Address 618 E. 28 Street

17 (a) (Burial, cremation, or removal) (b) Date thereof 6/17/47 (month) (day) (year)

(c) Cemetery or crematory Pr. Anthon

Location Baltimore Co.

18 (a) Funeral director Wm. George & Sons

(b) Address 611 Lanvale

19 JUN 16 1947 Huntington Williams, M.D.
(Date rec'd by registrar)

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MEDICAL CERTIFICATION

20. DATE OF DEATH 6-13-1941, at 9.25 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Life death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to aspiration of stomach contents.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 6-13-47 at 9/4 P M.

(b) Where did injury occur? 618 E 28th St

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No

(d) Means of injury aspiration of stomach Contents

23. Signature Earle V. Kaylor M.D.
Medical Examiner.

Date signed 6-14-47

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52611

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G52611

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3629 Yolando Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3629 Yolando Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alpha Edward Wherley
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Fannie Wherley
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 22, 1870
8. AGE: Years 77 Months 0 Days 22 If less than one day hr. min.
9. Birthplace New Rock, Pa. (Town, county, and state)
10. Usual Occupation Retired Railroad Conductor
11. Industry or business

FATHER
12. Name Abdiel Wherley
13. Birthplace Pa

MOTHER
14. Maiden Name Lavilla Reibolde
15. Birthplace Pa.

16 (a) Informant Mrs Fannie Wherley
(b) Address 3629 Yolando Road
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 16 1947 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.
18 (a) Funeral director Roland L. Fuchs
(b) Address 2112 Dundalk Ave.
19 JUN 16 1947 (Date rec'd by registrar) (b) Huntington, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 June 1947, at 1 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12 June 1947 to 13 June 1947, and that I last saw him alive on 12 June 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	13 June 1947
Due to Hypertensive Arteriosclerotic	7 years
Due to Cardiac vascular disease	
Other Conditions Hematuria see, to benign prostatic Hypertrophy	12 June 1947

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howard B. Sharp M. D.
Address 715 N. Charles St Date signed 13 June 1947
Baltimore Md

VS 150

G52615

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 169

Registered No. G52615

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 ds.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1108 Carson Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leroy Marshall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1908

8. AGE: Years 39 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Phila. Pa.
(Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER
12. Name James Marshall
13. Birthplace Va.

MOTHER
14. Maiden Name Ada. Jones
15. Birthplace Va.

16 (a) Informant James Marshall Jr.
(b) Address 20 28 Watkins St. Phila

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/16/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Fr. L. Co. Md.

18 (a) Funeral director Metropolitan Funeral
(b) Address 937 N. Monroe St

19 (a) JUN 16 1947 (Registrar) Huntington, West Virginia

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8, 1947 at 6 a. M. 30

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Ruptured liver, abdominal hemorrhage, fractured skull, crushed chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5:05 a.m. at 6-8-47
(b) Where did injury occur? P.R.R. Tunnel, Fulton Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? P.R.R. Prop. While at work? No
(d) Means of injury Pedestrian struck by train

23. Signature George S. Merrill M.D.
Medical Examiner.
Date signed 6/9/47

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C52616

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52

Registered No. C52616

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: UNIV HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 335 Paddington Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HELEN W GRIMES

3 (b) If veteran, name war -

3 (c) Social Security Account No. -

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Philip H. Grimes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25, 1896

8. AGE: Years 51 | Months 4 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Frank M. Wilcoxon
13. Birthplace Frederick, Md.

MOTHER 14. Maiden Name Addie Keefer
15. Birthplace Frederick, Md.

16 (a) Informant Mr. Philip H. Grimes
(b) Address 335 Paddington Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/18/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

JUN 16 1947 (Date rec'd by registrar)

(b) Hon. Wm. Preston Lane, Jr. Governor

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 JUNE 1947, at 1.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 14 JUNE 1947 to 15 JUNE 1947 and that I last saw her alive on 15 JUNE 1947

Immediate cause of death	Duration
RESPIRATORY PARALYSIS	
Due to AMYOTROPHIC LATERAL SCLEROSIS & BULBAR PALSY	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert B. Baner M. D.
Address University Hospital Date signed 15 June 47

X

PRINT NAME, AND, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52617

JL - 96709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G52617

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 - 7- 28
(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1513 Linden Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Latimer Lowe

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Maude E. Lowe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12, 1872

8. AGE: Years	Months	Days	If less than one day
75	2	2	hr. min.

9. Birthplace Pa. (Shrewsbury)
(Town, county, and state)
10. Usual Occupation -
11. Industry or business

FATHER
12. Name Joshua M. Lowe
13. Birthplace Md.

MOTHER
14. Maiden Name Wilhelmina Latimer
15. Birthplace Savannah, Ga.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 6/16/47 (month) (day) (year)
(c) Cemetery or crematory Lutheran Cem.
Location Shrewsbury, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUN 16 1947 (b) [illegible] Williamson, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14, 1947 19 , at 8.10A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-16 1945, to June 14 1947, and that I last saw him alive on June 14 1947

Immediate cause of death	Duration
[redacted] Carcinoma Pancreas	
Due to Coronary Occlusion	2 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. C. Robinson Jr. M. D.
Address B.M. City Hosp. Date signed 6/17/47

X

G52618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 138

Registered No. G52618

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2699 Wilkins Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2699 Wilkins Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jeanette Levin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1922

8. AGE: Years 25 | Months | Days | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation ✓

11. Industry or business

FATHER 12. Name Abe Levin
13. Birthplace Russia

MOTHER 14. Maiden Name Bertha
15. Birthplace Russia

16 (a) Informant Abe Levine
(b) Address 2699 Wilkins ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-16-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Jack Lewis Inc
18 (a) Funeral director 1439 E. Baltimore St
(b) Address

19 (a) JUN 16 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-16 1947 at 3A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1946 to 6-16 1947 and that I last saw h[illegible] alive on 6-15 1947

Immediate cause of death: Pulm. Tbc. — Duration 2 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. H. A. Shilling M. D.
Address 2426 Eutaw Pl Date signed 6-16-47

G52619

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G52619

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1537 N. Broadway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1537 N. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ADA MAY TODD

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Lionel Emmett Todd
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) May 19.1883

8. AGE: Years	Months	Days	If less than one day
61	0	23	....hr. ....min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Clinton C. Morris
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Virginia Frederick
15. Birthplace Baltimore

16 (a) Informant Mr. Lionel E. Todd (Husband)
(b) Address 1537 N. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 16. 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore Md.

18 (a) Funeral director HENRY SANDER & SONS. INC.
(b) Address 847 North Ave. & 2 Broadway

19 JUN 16 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12. 1947 at 2.25A M

21. I certify that death occurred on the date above stated; that I attended deceased from December 18 1946 to June 12 1947, and that I last saw h[illegible] alive on June 11. 1947

Immediate cause of death Cerebral Hemorrhage and Cardiac Dilatation — Duration 2 Days

Due to Cardiac Hypertension Disease — 5 4 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert Rosenberg M. D.
Address 2025 E North Ave Date signed 6-12-47

G52620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Registered No. G52620

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3308 Hudson St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3308 Hudson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie Dorothy Hood

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Harry A. Hood
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) March 4- 1887

8. AGE: Years	Months	Days	If less than one day
60	3	7	....hr. ....min.

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Schaefer
13. Birthplace Germany

MOTHER
14. Maiden Name Sophia Spies
15. Birthplace Germany

16 (a) Informant Mr. Harry A.Hood
(b) Address 3308 Hudson St.

17 (a) Burial (b) Date thereof June, 16 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address 1649 E. North Ave

19 (a) JUN 16 1947 Huntington Williams, Reg. (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11, 1947 at 6:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from January 1947 to Jun 1947 and that I last saw him alive on June 6, 1947

Immediate cause of death Myocardial failure — Duration 2 Days
Due to Carcinoma of Pancreas with metastasis to liver — 1½ years
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clarence W. LeGrow M.D.
Address 601 S. Elwood Ave. Date signed 6/16/47

X

0526621
AB-107122

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45B

Registered 0526621

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5mos. 16days
(e) Length of stay in Baltimore (yrs., mos., or days) most of life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2696 Wilkins Ave & Brunswick
(If rural give location) Zone 23
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Sinclair

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Widower

6 (b) Name of husband or wife Fanny (D

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 20- 1852

8. AGE: Years	Months	Days	If less than one day
94	7	23	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name August Sinclair
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Grutter
15. Birthplace Hamburg, Germany

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-16-47 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location E. Lamvendgon Ave.

18 (a) Funeral director Joseph F. Appleyard Jr.
(b) Address 414 N. Franklintown Rd.

19 (a) (b)
Registered by
JUN 16 1947
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13- 1947, at 8.31 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-27- 1946 to 6-13- 1947, and that I last saw h im alive on 6-13- 1947

Immediate cause of death Carcinoma of Tongue with metastases — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 3-18-47

Major findings of operation: Absent.

of autopsy: Absent

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Maurice M. Lacy M. D.
Address Baltimore City Hosp. Date signed 6-14-47

G526,22

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

Registered No. G526,22

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3029 McElderry
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3029 McElderry St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LEMONIA A PADUSSIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Konstantinc.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/18 95

8. AGE: Years 51 · Months 10 · Days · If less than one day ..... hr. ..... min.

9. Birthplace Chios Greece. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Markos
13. Birthplace Greece.

MOTHER
14. Maiden Name Theodora
15. Birthplace Greece

16 (a) Informant Son.
(b) Address 3029 McElderry

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof 6/16/47 (month) (day) (year)
(c) Cemetery or crematory Greenlawn
Location Wilkens Ave

18 (a) Funeral director Saunders Sons-Home
(b) Address 438-40-E. North Ave.

19 (a) JUN 16 1947 (b) Registrar for Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1947, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to June 12 1947 and that I last saw h[illegible] alive on June 12 1947

Immediate cause of death: Chronic myocarditis — Duration: 1 yr

Due to: Chr. glomerulonephritis with Hypertension — 9 yrs

Due to: disease probably to Nephrosclerosis — 1 yr

Other Conditions: Diabetes Mellitus ? (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert B. Taylor M. D.
Address 104 W. Madison St Date signed 6/16/47

131a

G52623

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G52623 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1515 CLARKSON ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1515 CLARKSON ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BARBARA RITTERICH.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex FEM | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced MARRIED

6 (b) Name of husband or wife JOHN A RITTERICH

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT 15-1884

8. AGE: Years 62 | Months 4 | Days 30 | If less than one day hr. min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual Occupation HOUSE WORK-

11. Industry or business AT HOME

FATHER
12. Name CHRISTIAN ROTHER
13. Birthplace GERMANY

MOTHER
14. Maiden Name AGNES LEFFLER
15. Birthplace GERMANY

16 (a) Informant JOHN A RITTERICH.
(b) Address 1515 CLARKSON ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JUNE-17 47 (month) (day) (year)
(c) Cemetery or crematory HOLY CROSS
Location A. A. Co

18 (a) Funeral director Bernard C Hanke
(b) Address 121 E West St

19 (a) (Date rec'd by registrar) Huntington Williams, M.D.

JUN 16 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 1947, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/10/ 1947 to June 14 1947.
and that I last saw deceased alive on June 12 1947

	Duration
Immediate cause of death: Cardiac Thrombosis	1 hr.
Due to: Senile Myocarditis	15 mos.
Due to: Bronchopneumonia	2 wks.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. F. VanGorder
Address 1515 Clarkson St. Date signed 6/16/47 M.D.

X

NOTICE: Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52624

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G52624 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3517 O'Donnell St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3517 O'Donnell St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Drescher

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Anna Monica
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 31, 1873

8. AGE: Years	Months	Days	If less than one day
73	7	13 12	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Brewer - Free State
11. Industry or business Free State Brewery

FATHER
12. Name — Drescher
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Anna Drescher
(b) Address 3517 O'Donnell St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 17 47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem.
Location Gwynnbrook Road.

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 1103 E. Fayette Street

19 (a) (b) Registrar

JUN 16 1947 Huntington Williams, MD

VS 110

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-13-1947, at 11:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1947 to June 13 1947, and that I last saw h[illegible] alive on 6-12-1947.

Immediate cause of death Hypertension
Arteriosclerosis C.V.Disease.
Chr. Myocarditis
Due to Congenital Failure.
Due to
Other Conditions Chr. Hypertrophic Prostatis
Chr. Arthritis
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

Duration
Jan 2/47
June 1-47

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature F. A. Schemmenk M. D.
Address 842 E. Eager Ave. Date signed 6-16-47

X

...correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52625

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G52625 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1926 Gough St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1926 Gough St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hetty (or Lena) Zittel
3 (b) If veteran, name war None
3 (c) Social Security Account No. 217-03-038

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Frank
6 (c) If alive, give age 88 years

7. Birth date of deceased (mo., day, yr.) March 6, 1874

8. AGE: Years 73 | Months 3 | Days 9 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER 12. Name Jacob Edmanski
FATHER 13. Birthplace Germany
MOTHER 14. Maiden Name Anna ?
MOTHER 15. Birthplace Germany

16 (a) Informant William Zittel
(b) Address 135 S. Chapel St.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 6/16/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director H. W. E. Dippel's Sons
(b) Address Lombard & Gay Sts.

19 (a) 1947 JUN 16 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15, 1947, at 10 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy & Inq thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Artery disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D. Medical Examiner.
Date signed 6/16/47

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly. Use typewriter if convenient.

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

CERTIFICATION

THIS IS TO CERTIFY THAT ON THIS 8 23 DAY OF 1963 THE MICROPHOTOGRAPHS APPEARING HEREIN STARTING WITH 49326 AND ENDING WITH 52625 ARE ACCURATE AND COMPLETE REPRODUCTIONS OF THE RECORDS OF THE DEPARTMENT OF Health BUREAU OF Vital Statistics AS DELIVERED IN THE REGULAR COURSE OF BUSINESS FOR PHOTOGRAPHING, AND THAT:

TO THE BEST OF MY KNOWLEDGE THE MICROFILM MEETS THE REQUIREMENTS OF THE NATIONAL BUREAU OF STANDARDS FOR PERMANENT MICROPHOTOGRAPHIC COPY.

CAMERA OPERATOR: Loretta Byrne

END OF REEL